SERFF Tracking Number:	*ANTX-126249188*	*State:*	*Arkansas*
Filing Company:	*American National Life Insurance Company of Texas*	*State Tracking Number:*	*43144*
Company Tracking Number:			
TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15G.002 Large Group Only*
Product Name:	*NBA 09 AR*		
Project Name/Number:	*NBA 09 AR/*		

Filing at a Glance

Company: American National Life Insurance Company of Texas

Product Name: NBA 09 AR	SERFF Tr Num: ANTX-126249188	State: Arkansas
TOI: H15G Group Health - Hospital/Surgical/Medical Expense	SERFF Status: Closed-Approved-Closed	State Tr Num: 43144
Sub-TOI: H15G.002 Large Group Only	Co Tr Num:	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Rosalind Minor
	Author: Deborah Biediger	Disposition Date: 09/03/2009
	Date Submitted: 08/06/2009	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: NBA 09 AR	Status of Filing in Domicile: Authorized
Project Number:	Date Approved in Domicile: 06/01/2009
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Large
Overall Rate Impact:	Group Market Type: Association
Filing Status Changed: 09/03/2009	Explanation for Other Group Market Type:
	State Status Changed: 09/03/2009
Deemer Date:	Created By: Deborah Biediger
Submitted By: Deborah Biediger	Corresponding Filing Tracking Number:

Filing Description:

Group Policy ANL-C09-P and Certificate ANL-C09-C (AR), is an Association Group Hospital Insurance Policy, which will be issued to the National Business Association, Inc (NBA),
which is situsedin Missouri.
There are three plan options built into the Policy.
1. PPO and Indemnity Plan (Option A). If issued as a PPO Plan, Rider ANL-PPO09 will be attached to the Certificate;
2. PPO and Indemnity Plus Plan (Option B). If issued as a PPO Plan, Rider ANL-PPOB09 will be attached to the Certificate;

3. PPO and Indemnity HSA Plan. Amendment ANL-HQA09 is issued with both the indemnity and PPO Plan. If issued as a PPO Plan, Rider ANL-PPOH09 will also be attached to the Certificate.

The following Riders are also available with Plans A and B (not the HSA plan):
ANL-ACC09, Outpatient Accident Expense Benefit Rider;
ANL-DIR09, Outpatient Diagnostic Imaging Rider;
ANL-OPD09 (AR), Outpatient Doctor Rider;
ANL-OPRx09 (AR), Outpatient Prescription Drug Rider; and
ANL-CBB09, Childbirth Benefit Rider

Rider ANL-RES09 is a no-cost Restoration of Benefits Rider that is available with Plans A, B and HSA.

The Application for coverage is form ANTEX-NBA-CAT09. The Agent may use this Application or the EZ Application, form ANTEX-NBA-Cat09(EZ). The agent uses the EZ Application in connection with either form PHE-NBA08S, which is a Personal History Interview Form that uses a wet signature, or form PHE-NBA08VS, which is a Personal History Interview Form that uses a voice signature.

The CONSUMER INFORMATION NOTICE, ANL-CIN (AR), will be included in all new issues of the certificate.

Company and Contact

Filing Contact Information

Deborah Biediger, Sr Compliance	deborah.biediger@anico.com
One Moody Plaza 17th Floor	409-766-6691 [Phone]
Galveston, TX 77550	409-766-2024 [FAX]

Filing Company Information

American National Life Insurance Company of Texas	CoCode: 71773	State of Domicile: Texas
One Moody Plaza 17th Floor	Group Code: -99	Company Type: Health Insurance
Galveston, TX 77550	Group Name:	State ID Number:
(409) 621-7779 ext. [Phone]	FEIN Number: 75-1016594	

Filing Fees

SERFF Tracking Number:	*ANTX-126249188*	*State:*	*Arkansas*
Filing Company:	*American National Life Insurance Company of Texas*	*State Tracking Number:*	*43144*
Company Tracking Number:			
TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15G.002 Large Group Only*
Product Name:	*NBA 09 AR*		
Project Name/Number:	*NBA 09 AR/*		

Fee Required?	Yes
Fee Amount:	$100.00
Retaliatory?	Yes
Fee Explanation:	$100.00 retaliatory
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American National Life Insurance Company of Texas	$100.00	08/06/2009	29669437

SERFF Tracking Number:	*ANTX-126249188*	*State:*	*Arkansas*
Filing Company:	*American National Life Insurance Company of Texas*	*State Tracking Number:*	*43144*
Company Tracking Number:			
TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15G.002 Large Group Only*
Product Name:	*NBA 09 AR*		
Project Name/Number:	*NBA 09 AR/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	09/03/2009	09/03/2009

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Rosalind Minor	09/02/2009	09/02/2009	Deborah Biediger	09/03/2009	09/03/2009

SERFF Tracking Number:	*ANTX-126249188*	*State:*	*Arkansas*
Filing Company:	*American National Life Insurance Company of Texas*	*State Tracking Number:*	*43144*
Company Tracking Number:			
TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15G.002 Large Group Only*
Product Name:	*NBA 09 AR*		
Project Name/Number:	*NBA 09 AR/*		

Disposition

Disposition Date: 09/03/2009
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*ANTX-126249188*	*State:*	*Arkansas*
Filing Company:	*American National Life Insurance Company of Texas*	*State Tracking Number:*	*43144*
Company Tracking Number:			
TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15G.002 Large Group Only*
Product Name:	*NBA 09 AR*		
Project Name/Number:	*NBA 09 AR/*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Master Policy	Approved-Closed	Yes
Supporting Document	NBA bylaws and articles of incorporation	Approved-Closed	Yes
Supporting Document	Executed offers to Policyholder, the NBA	Approved-Closed	Yes
Form *(revised)*	Certificate	Approved-Closed	Yes
Form	Certificate	Replaced	Yes
Form *(revised)*	MASTER POLICY AMENDMENT ARKANSAS RESIDENTS	Approved-Closed	Yes
Form	MASTER POLICY AMENDMENT ARKANSAS RESIDENTS	Replaced	Yes
Form	Enrollment Application	Approved-Closed	Yes
Form	EZ Enrollment Application	Approved-Closed	Yes
Form	EZ Personal History Interview Form	Approved-Closed	Yes
Form	EZ Personal History Interview Form	Approved-Closed	Yes
Form	OUTPATIENT ACCIDENT EXPENSE BENEFIT RIDER	Approved-Closed	Yes
Form	Childbirth Benefit Rider	Approved-Closed	Yes
Form	OUTPATIENT DIAGNOSTIC IMAGING RIDER	Approved-Closed	Yes
Form	Amendment	Approved-Closed	Yes
Form	Preferred Provider Rider	Approved-Closed	Yes
Form	PPO Rider	Approved-Closed	Yes
Form	PPO Rider	Approved-Closed	Yes
Form	PPO Rider	Approved-Closed	Yes
Form	Outpatient Doctor Rider	Approved-Closed	Yes
Form	Outpatient Prescription Drug Rider	Approved-Closed	Yes
Form	Consumer Information Notice	Approved-Closed	Yes

SERFF Tracking Number:	*ANTX-126249188*	*State:*	*Arkansas*
Filing Company:	*American National Life Insurance Company of Texas*	*State Tracking Number:*	*43144*
Company Tracking Number:			
TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15G.002 Large Group Only*
Product Name:	*NBA 09 AR*		
Project Name/Number:	*NBA 09 AR/*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	09/02/2009
Submitted Date	09/02/2009
Respond By Date	

Dear Deborah Biediger,

This will acknowledge receipt of the captioned filing.

Objection 1

- Certificate, ANL-C09-C (AR) (Form)

Comment:

Under the Conversion Privilege, it is stated that the insured must be covered during three months up until the time of termination. This is a limitation which is not required under our Conversion law ACA 23-86-115.

Objection 2

- Certificate, ANL-C09-C (AR) (Form)

Comment:

The certificate must contain language for State Continuation as outlined under ACA 23-86-114.

Objection 3

- Enrollment Application, ANTEX-NBA-CAT09 (Form)
- EZ Enrollment Application, ANTEX-NBA-CAT09(EZ) (Form)

Comment: With respect to benefits for TMJ, the policyholder shall accept or reject the optional coverage in writing on the application as required by ACA 23-79-150(c)(1).

The application shall specifically and conspicuously inform the policyholder that rejection of the option means that covered benefits provided to insureds or enrollees will not include temporomandibular joint disorder or craniomandibular disorder. Refer to ACA 23-79-150(c)(2).

Please feel free to contact me if you have questions.

Sincerely,

SERFF Tracking Number:	*ANTX-126249188*	*State:*	*Arkansas*
Filing Company:	*American National Life Insurance Company of Texas*	*State Tracking Number:*	*43144*
Company Tracking Number:			
TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15G.002 Large Group Only*
Product Name:	*NBA 09 AR*		
Project Name/Number:	*NBA 09 AR/*		

Rosalind Minor

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	09/03/2009
Submitted Date	09/03/2009

Dear Rosalind Minor,

Comments:
Thank you for your review of this filing.

Response 1

Comments: I have revised the certificate and the policy amendment to comply with 23-86-115. A redlined version of the certificate is also attached highlighting this revision.

Related Objection 1

Applies To:

- Certificate, ANL-C09-C (AR) (Form)

Comment:

Under the Conversion Privilege, it is stated that the insured must be covered during three months up until the time of termination. This is a limitation which is not required under our Conversion law ACA 23-86-115.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Certificate	ANL-C09-		Certificate	Initial			sept clean

SERFF Tracking Number:	*ANTX-126249188*	*State:*	*Arkansas*
Filing Company:	*American National Life Insurance Company of Texas*	*State Tracking Number:*	*43144*
Company Tracking Number:			
TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15G.002 Large Group Only*
Product Name:	*NBA 09 AR*		
Project Name/Number:	*NBA 09 AR/*		

	C (AR)				cert.pdf,sept redlined cert.pdf
Previous Version					
Certificate	*ANL-C09-C (AR)*	*Certificate*	*Initial*		ANL-C09-C.pdf

No Rate/Rule Schedule items changed.

Response 2

Comments: I have revised the certificate and the policy amendment adding a section for State Continuation.
A redlined version of the certificate showing the revision is also attached.

Related Objection 1

Applies To:

- Certificate, ANL-C09-C (AR) (Form)

Comment:

The certificate must contain language for State Continuation as outlined under ACA 23-86-114.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Certificate	ANL-C09-C (AR)		Certificate	Initial			sept clean cert.pdf,sept redlined cert.pdf
Previous Version							

SERFF Tracking Number:	*ANTX-126249188*	*State:*	*Arkansas*
Filing Company:	*American National Life Insurance Company of Texas*	*State Tracking Number:*	*43144*
Company Tracking Number:			
TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15G.002 Large Group Only*
Product Name:	*NBA 09 AR*		
Project Name/Number:	*NBA 09 AR/*		

Certificate	*ANL-C09-C (AR)*	*Certificate*	*Initial*	ANL-C09-C.pdf
MASTER POLICY AMENDMENT ARKANSAS RESIDENTS	09 POL AMEND (AR)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Initial	revised MASTER POLICY AMENDMENT.pdf
Previous Version				
MASTER POLICY AMENDMENT ARKANSAS RESIDENTS	*09 POL AMEND (AR)*	*Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider*	*Initial*	MASTER POLICY AMENDMENT non HSA AR.pdf

No Rate/Rule Schedule items changed.

Response 3

Comments: I have attached the executed offers made to the Policyholder including the TMJ offer.
The application signed by the Policyholder, the NBA, is a separate document, but the executed offers are made part of that application. The individual members of the NBA complete the applications attached to this submission.

Related Objection 1

Applies To:

- Enrollment Application, ANTEX-NBA-CAT09 (Form)
- EZ Enrollment Application, ANTEX-NBA-CAT09(EZ) (Form)

Comment:
With respect to benefits for TMJ, the policyholder shall accept or reject the optional coverage in writing on the application as required by ACA 23-79-150(c)(1).

The application shall specifically and conspicuously inform the policyholder that rejection of the option means that covered benefits provided to insureds or enrollees will not include temporomandibular joint disorder or craniomandibular disorder. Refer to ACA 23-79-150(c)(2).

Changed Items:

SERFF Tracking Number:	*ANTX-126249188*	*State:*	*Arkansas*
Filing Company:	*American National Life Insurance Company of Texas*	*State Tracking Number:*	*43144*
Company Tracking Number:			
TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15G.002 Large Group Only*
Product Name:	*NBA 09 AR*		
Project Name/Number:	*NBA 09 AR/*		

Supporting Document Schedule Item Changes

Satisfied -Name: Executed offers to Policyholder, the NBA

Comment: The application filled out by the individual member of the association, the NBA, is not the same application filled out by the Policyholder, the NBA.

Historically, mandated offers are separate documents from the Policyholder's application, but become part of the Policyholder application.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Thank you for your continued review of this submission.

Sincerely,
Deborah Biediger

SERFF Tracking Number:	*ANTX-126249188*	*State:*	*Arkansas*
Filing Company:	*American National Life Insurance Company of Texas*	*State Tracking Number:*	*43144*
Company Tracking Number:			
TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15G.002 Large Group Only*
Product Name:	*NBA 09 AR*		
Project Name/Number:	*NBA 09 AR/*		

Form Schedule

Lead Form Number: ANL-C09-C (AR)

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 09/03/2009	ANL-C09-C (AR)	Certificate	Certificate	Initial			sept clean cert.pdf sept redlined cert.pdf
Approved-Closed 09/03/2009	09 POL AMEND (AR)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	MASTER POLICY AMENDMENT ARKANSAS RESIDENTS	Initial			revised MASTER POLICY AMENDMENT.pdf
Approved-Closed 09/03/2009	ANTEX-NBA-CAT09	Application/Enrollment Form	Enrollment Application	Initial			ANTEX-NBA-CAT09 file ver.pdf
Approved-Closed 09/03/2009	ANTEX-NBA-CAT09(EZ)	Application/Enrollment Form	EZ Enrollment Application	Initial			ANTEX-NBA-CAT09(EZ) file ver.pdf
Approved-Closed 09/03/2009	PHE-NBA08S	Application/Enrollment Form	EZ Personal History Interview Form	Initial			PHE-NBA08S.pdf
Approved-Closed 09/03/2009	PHE-NBA08VS	Application/Enrollment Form	EZ Personal History Interview Form	Initial			PHE-NBA08SVS.pdf
Approved-Closed 09/03/2009	ANL-ACC09	Certificate Amendment, Insert Page,	OUTPATIENT ACCIDENT EXPENSE BENEFIT RIDER	Initial			ANL-ACC09.pdf

SERFF Tracking Number:	*ANTX-126249188*		*State:*	*Arkansas*		
Filing Company:	*American National Life Insurance Company of Texas*		*State Tracking Number:*	*43144*		
Company Tracking Number:						
TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense*		*Sub-TOI:*	*H15G.002 Large Group Only*		
Product Name:	*NBA 09 AR*					
Project Name/Number:	*NBA 09 AR/*					
Approved-Closed 09/03/2009	ANL-CBB09	Endorsement or Rider Certificate Amendment, Insert Page, Endorsement or Rider	Childbirth Benefit Rider	Initial		ANL-CBB09.pdf
Approved-Closed 09/03/2009	ANL-DIR09	Certificate Amendment, Insert Page, Endorsement or Rider	OUTPATIENT DIAGNOSTIC IMAGING RIDER	Initial		ANL-DIR09.pdf
Approved-Closed 09/03/2009	ANL-HAQ09	Certificate Amendment, Insert Page, Endorsement or Rider	Amendment	Initial		ANL-HQA09.pdf
Approved-Closed 09/03/2009	ANL-PPO09	Certificate Amendment, Insert Page, Endorsement or Rider	Preferred Provider Rider	Initial		ANL-PPO09.pdf
Approved-Closed 09/03/2009	ANL-PPOB09	Certificate Amendment, Insert Page, Endorsement or Rider	PPO Rider	Initial		ANL-PPOB09.pdf
Approved-Closed 09/03/2009	ANL-PPOH09	Certificate Amendment, Insert Page,	PPO Rider	Initial		ANL-PPOH09.pdf

SERFF Tracking Number:	*ANTX-126249188*		*State:*	*Arkansas*		
Filing Company:	*American National Life Insurance Company of Texas*		*State Tracking Number:*	*43144*		
Company Tracking Number:						
TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense*		*Sub-TOI:*	*H15G.002 Large Group Only*		
Product Name:	*NBA 09 AR*					
Project Name/Number:	*NBA 09 AR/*					
Approved-Closed 09/03/2009	ANL-RES09	Endorsement or Rider Certificate Amendment, Insert Page, Endorsement or Rider	PPO Rider	Initial		ANL-RES09.pdf
Approved-Closed 09/03/2009	ANL-OPD09 (AR)	Endorsement or Rider Certificate Amendment, Insert Page, Endorsement or Rider	Outpatient Doctor Rider	Initial		ANL-OPD09 AR .pdf
Approved-Closed 09/03/2009	ANL-OPRx09 (AR)	Endorsement or Rider Certificate Amendment, Insert Page, Endorsement or Rider	Outpatient Prescription Drug Rider	Initial		ANL-OPRx09 AR.pdf
Approved-Closed 09/03/2009	ANL-CIN (AR)	Notice of Coverage	Consumer Information Notice	Initial		CONSUMER INFORMATION NOTICE.pdf

AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS

A Stock Life Insurance Company
HOME OFFICE: ONE MOODY PLAZA
GALVESTON, TEXAS 77550

GROUP HOSPITAL INSURANCE CERTIFICATE

We pay benefits in accordance with all the terms and conditions of the Group Policy for Medical Service charges that are described in the section called "Medical Services" and incurred by a Covered Person as the result of the Medically Necessary treatment of:

INJURY that occurs after his/her Certificate Date; or

SICKNESS that begins after his/her Certificate Date.

This Certificate is not the contract of insurance, however it provides evidence of coverage under the Group Policy. **READ IT CAREFULLY.**

IMPORTANT NOTICE CONCERNING STATEMENTS IN YOUR ENROLLMENT APPLICATION - You should read Your Enrollment Application and all documents attached to this Certificate. **Omissions or misstatements in Your Enrollment Application or any attached documents may cause Us to deny an otherwise valid claim or rescind coverage.** Carefully check all documents. You must advise Our Underwriting Department in writing within 10 days of Your receipt of this Certificate if You determine that any information or medical history is incomplete, incorrect, or has changed since the date of Your Enrollment Application.

Your Enrollment Application and all attached documents are part of the Group Policy. We provide coverage described in the Group Policy on the basis that all of the answers to the questions and all the material information contained in the documents are correct and complete. No agent or employee, except an officer of the Company, has the authority to waive any of the requirements in the documents or waive any of the provisions of the Group Policy.

We do not provide coverage until we have approved Your Enrollment Application and Your Initial Premium has been paid. The Initial Premium pays for the Initial Term of coverage. The Initial Term of coverage begins at 12:01 A.M., local time, at Your residence on Your Certificate Date. Coverage is continued in accordance with all of the provisions of the Group Policy.

10 DAY RIGHT TO EXAMINE THIS CERTIFICATE – You may return this Certificate to Us for any reason within 10 days after You receive it. You may bring it in person or mail it to Us. At the time You return this Certificate, coverage under the Group Policy is void from the beginning. We will refund any premium paid.

PREMIUMS ARE SUBJECT TO CHANGE - Please refer to the section titled **PREMIUMS**.

THE GROUP POLICY – You may review the Group Policy during usual business hours at the Group Policyholder's office.

SECRETARY

PRESIDENT

THE GROUP POLICY PROVIDES COVERAGE FOR HOSPITAL EXPENSES DESCRIBED IN THE GROUP POLICY AND THIS CERTIFICATE. WHEN SELECTED, A PREFERRED PROVIDER COMPONENT IS INCLUDED WITH THIS COVERAGE.

CERTIFICATE SCHEDULE

REMARKS - SEE ANY ATTACHED FORMS

NOTICE –

BENEFIT OPTION – A
COVERAGE – INDIVIDUAL/ FAMILY
DEDUCTIBLE AMOUNT – ($750, $1,500, $2,000, $2,500, $5,000, $10,000, $15,000, $20,000, $25,000) PER COVERED PERSON PER CALENDAR YEAR
RATE OF PAYMENT – (100%, 80%, 50%)
STOP-LOSS AMOUNT - ($5,000, $10,000)
MAXIMUM POLICY BENEFIT FOR EACH INJURY OR SICKNESS PER COVERED PERSON -- $1,000,000 ($2,000,000)

REFER TO MEDICAL SERVICES FOR A DESCRIPTION OF EXPENSES COVERED BY THE POLICY.
REFER TO EXCEPTIONS FOR A DESCRIPTION OF EXPENSES THAT ARE NOT COVERED BY THE POLICY.

CERTIFICATE NUMBER:
CERTIFICATE DATE:

COVERED PERSONS:	**RELATIONSHIP**	**AGE**	**DATE OF BIRTH**

GROUP POLICY NUMBER:
GROUP POLICY DATE:
GROUP POLICYHOLDER:
STATE OF ISSUE:

CERTIFICATE SCHEDULE

REMARKS - SEE ANY ATTACHED FORMS

NOTICE –

BENEFIT OPTION – A
COVERAGE – INDIVIDUAL/ FAMILY
DEDUCTIBLE AMOUNT – ($750, $1,500, $2,000, $2,500, $5,000, $10,000, $15,000, $20,000, $25,000) PER COVERED PERSON PER CALENDAR YEAR
RATE OF PAYMENT –
IN-NETWORK - (100%, 80%, 50%)
OUT-OF-NETWORK - (80% OF THE FIRST $5,000, 100% THEREAFTER)

(60% UP TO THE STOP LOSS AMOUNT, 100% THEREAFTER)

(30% UP TO THE STOP LOSS AMOUNT, 100% THEREAFTER)

STOP-LOSS AMOUNT - ($5,000, $10,000)
MAXIMUM POLICY BENEFIT FOR EACH INJURY OR SICKNESS PER COVERED PERSON -- $1,000,000 ($2,000,000)

REFER TO MEDICAL SERVICES FOR A DESCRIPTION OF EXPENSES COVERED BY THE POLICY.
REFER TO EXCEPTIONS FOR A DESCRIPTION OF EXPENSES THAT ARE NOT COVERED BY THE POLICY.

CERTIFICATE NUMBER:
CERTIFICATE DATE:

COVERED PERSONS:	**RELATIONSHIP**	**AGE**	**DATE OF BIRTH**

GROUP POLICY NUMBER:
GROUP POLICY DATE:
GROUP POLICYHOLDER:
STATE OF ISSUE:

CERTIFICATE SCHEDULE

REMARKS - SEE ANY ATTACHED FORMS

NOTICE –

BENEFIT OPTION – B

RATE OF PAYMENT – (100%)
DEDUCTIBLE AMOUNT – ($3,000, $4,000, $5,000, $10,000)
UNPAID MEDICAL SERVICE
CHARGE MAXIMUM - ($3,000, $4,000, $5,000, $10,000) INCLUDES DEDUCTIBLE

RATE OF PAYMENT – (80%)
DEDUCTIBLE AMOUNT – ($3,000, $4,000, $5,000, $10,000)
UNPAID MEDICAL SERVICE
CHARGE MAXIMUM - ($7,000, $8,000, $9,000, $14,000) INCLUDES DEDUCTIBLE

RATE OF PAYMENT – (50%)
DEDUCTIBLE AMOUNT – ($3,000, $4,000, $5,000, $10,000)
UNPAID MEDICAL SERVICE
CHARGE MAXIMUM - ($8,000, $9,000, $10,000, $15, 000) INCLUDES DEDUCTIBLE

MAXIMUM POLICY BENEFIT FOR EACH
INJURY OR SICKNESS PER COVERED PERSON -- $1,000,000 ($2,000,000)

REFER TO MEDICAL SERVICES FOR A DESCRIPTION OF EXPENSES COVERED BY THE POLICY.
REFER TO EXCEPTIONS FOR A DESCRIPTION OF EXPENSES THAT ARE NOT COVERED BY THE POLICY.

CERTIFICATE NUMBER:
CERTIFICATE DATE:

COVERED PERSONS:	**RELATIONSHIP**	**AGE**	**DATE OF BIRTH**

GROUP POLICY NUMBER:
GROUP POLICY DATE:
GROUP POLICYHOLDER:
STATE OF ISSUE:

CERTIFICATE SCHEDULE

REMARKS - SEE ANY ATTACHED FORMS

NOTICE –

BENEFIT OPTION – B

RATE OF PAYMENT –
IN-NETWORK - (100%)
OUT-OF-NETWORK - (80%)
DEDUCTIBLE AMOUNT – ($3,000, $4,000, $5,000, $10,000)
UNPAID MEDICAL SERVICE
CHARGE MAXIMUM - ($3,000, $4,000, $5,000, $10,000) INCLUDES DEDUCTIBLE

RATE OF PAYMENT –
IN-NETWORK – (80%)
OUT-OF-NETWORK - (60%)
DEDUCTIBLE AMOUNT – ($3,000, $4,000, $5,000, $10,000)
UNPAID MEDICAL SERVICE
CHARGE MAXIMUM - ($7,000, $8,000, $9,000, $14,000) INCLUDES DEDUCTIBLE

RATE OF PAYMENT –
IN-NETWORK - (50%)
OUT-OF-NETWORK - (30%)
DEDUCTIBLE AMOUNT – ($3,000, $4,000, $5,000, $10,000)
UNPAID MEDICAL SERVICE
CHARGE MAXIMUM - ($8,000, $9,000, $10,000, $15, 000) INCLUDES DEDUCTIBLE

MAXIMUM POLICY BENEFIT FOR EACH
INJURY OR SICKNESS PER COVERED PERSON -- $1,000,000 ($2,000,000)

REFER TO MEDICAL SERVICES FOR A DESCRIPTION OF EXPENSES COVERED BY THE POLICY.
REFER TO EXCEPTIONS FOR A DESCRIPTION OF EXPENSES THAT ARE NOT COVERED BY THE POLICY.

CERTIFICATE NUMBER:
CERTIFICATE DATE:
COVERED PERSONS: RELATIONSHIP AGE DATE OF BIRTH

GROUP POLICY NUMBER:
GROUP POLICY DATE:
GROUP POLICYHOLDER:
STATE OF ISSUE:

CERTIFICATE SCHEDULE

REMARKS - SEE ANY ATTACHED FORMS

THE PLAN DEDUCTIBLE AND UNPAID MEDICAL SERVICES MAXIMUM WILL CHANGE IN ACCORDANCE WITH FEDERAL REQUIREMENTS.

NOTICE –

COVERAGE – (INDIVIDUAL/ FAMILY**)**
BENEFIT OPTION – NOT APPLICABLE
RATE OF PAYMENT – (100%)
DEDUCTIBLE AMOUNT –
INDIVIDUAL - ($1,500, $2,000, $2,500, $5,000)
FAMILY - ($3,000, $4,000, $5,000, $10,000)
UNPAID MEDICAL SERVICE CHARGE MAXIMUM - **INDIVIDUAL** - ($1,500, $2,000, $2,500, $5,000) INCLUDES DEDUCTIBLE
FAMILY - ($3,000, $4,000, $5,000, $10,000) INCLUDES DEDUCTIBLE

RATE OF PAYMENT – (80%)
DEDUCTIBLE AMOUNT –
INDIVIDUAL - ($1,500, $2,000, $2,500)
FAMILY - ($3,000, $4,000, $5,000)
UNPAID MEDICAL SERVICE CHARGE MAXIMUM - **INDIVIDUAL** - ($3,500, $4,000, $4,500) INCLUDES DEDUCTIBLE
FAMILY - ($7,000, $8,000, $9,000) INCLUDES DEDUCTIBLE

RATE OF PAYMENT – (50%)
DEDUCTIBLE AMOUNT –
INDIVIDUAL - ($1,500, $2,000, $2,500)
FAMILY - ($3,000, $4,000, $5,000)
UNPAID MEDICAL SERVICE CHARGE MAXIMUM - **INDIVIDUAL** - ($4,000, $4,500, $5,000) INCLUDES DEDUCTIBLE
FAMILY - ($8,000, $9,000, $10,000) INCLUDES DEDUCTIBLE

MAXIMUM POLICY BENEFIT FOR EACH INJURY OR SICKNESS PER COVERED PERSON -- $1,000,000 ($2,000,000)

REFER TO MEDICAL SERVICES FOR A DESCRIPTION OF EXPENSES COVERED BY THE POLICY.
REFER TO EXCEPTIONS FOR A DESCRIPTION OF EXPENSES THAT ARE NOT COVERED BY THE POLICY.

CERTIFICATE NUMBER:
CERTIFICATE DATE:

COVERED PERSONS:	**RELATIONSHIP**	**AGE**	**DATE OF BIRTH**

GROUP POLICY NUMBER:
GROUP POLICY DATE:
GROUP POLICYHOLDER:
STATE OF ISSUE:

CERTIFICATE SCHEDULE

REMARKS - SEE ANY ATTACHED FORMS
THE PLAN DEDUCTIBLE AND UNPAID MEDICAL SERVICES MAXIMUM WILL CHANGE IN ACCORDANCE WITH FEDERAL REQUIREMENTS.

NOTICE –OUT-OF-NETWORK PENALTY – COVERAGE UNDER THE GROUP POLICY INCLUDES A PPO COMPONENT. THE CERTIFICATEHOLDER IS ENCOURAGED TO USE AN IN-NETWORK PROVIDER TO RECEIVE THE MAXIMUM AMOUNT PAYABLE FOR ELIGIBLE MEDICAL SERVICE CHARGES. USE OF AN OUT-OFNETWORK PROVIDER RESULTS IN A 20% REDUCTION OF ANY OTHERWISE ELIGIBLE MEDICAL SERVICE CHARGE THAT WE DO NOT PAY DUE TO A COVERED PERSON'S VOLUNTARY USE OF AN OUT-OF-NETWORK PROVIDER.

COVERAGE – (INDIVIDUAL/ FAMILY**)**
BENEFIT OPTION – NOT APPLICABLE
RATE OF PAYMENT – (100%)
DEDUCTIBLE AMOUNT –
INDIVIDUAL - ($1,500, $2,000, $2,500, $5,000)
FAMILY - ($3,000, $4,000, $5,000, $10,000)
UNPAID MEDICAL SERVICE
CHARGE MAXIMUM - INDIVIDUAL - ($1,500, $2,000, $2,500, $5,000) INCLUDES DEDUCTIBLE
FAMILY - ($3,000, $4,000, $5,000, $10,000) INCLUDES DEDUCTIBLE

RATE OF PAYMENT – (80%)
DEDUCTIBLE AMOUNT –
INDIVIDUAL - ($1,500, $2,000, $2,500)
FAMILY - ($3,000, $4,000, $5,000)
UNPAID MEDICAL SERVICE
CHARGE MAXIMUM - INDIVIDUAL - ($3,500, $4,000, $4,500) INCLUDES DEDUCTIBLE
FAMILY - ($7,000, $8,000, $9,000) INCLUDES DEDUCTIBLE

RATE OF PAYMENT – (50%)
DEDUCTIBLE AMOUNT –
INDIVIDUAL - ($1,500, $2,000, $2,500)
FAMILY - ($3,000, $4,000, $5,000)
UNPAID MEDICAL SERVICE
CHARGE MAXIMUM - INDIVIDUAL - ($4,000, $4,500, $5,000) INCLUDES DEDUCTIBLE
FAMILY - ($8,000, $9,000, $10,000) INCLUDES DEDUCTIBLE

MAXIMUM POLICY BENEFIT FOR EACH
INJURY OR SICKNESS PER COVERED PERSON -- $1,000,000 ($2,000,000)

REFER TO MEDICAL SERVICES FOR A DESCRIPTION OF EXPENSES COVERED BY THE POLICY.
REFER TO EXCEPTIONS FOR A DESCRIPTION OF EXPENSES THAT ARE NOT COVERED BY THE POLICY.

CERTIFICATE NUMBER:
CERTIFICATE DATE:
COVERED PERSONS: RELATIONSHIP AGE DATE OF BIRTH

GROUP POLICY NUMBER:
GROUP POLICY DATE:
GROUP POLICYHOLDER:
STATE OF ISSUE:

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PREMIUMS

Premiums are due on the first day of each term that follows the Initial Term. This is called the Premium Due Date. The required premium will depend on Your premium class. We determine the premium class on each Premium Due Date. We will NOT CHANGE Your premium prior to the first anniversary of Your Certificate Date, unless:

1. Coverage changes; or
2. Residence changes.

After the first anniversary of Your coverage, We will change premiums:

1. Annually, based on attained age;
2. When You move to a different rating zone; or
3. Anytime, and from time to time, that We decide to change rates for persons in Your or a Covered Person's class.

Changes will apply to premiums due on or after the effective date of the change. The new rates will apply on a class basis as determined by Us. We will give You 30 days notice before any premium change.

WAIVER OF PREMIUM - If You die, We will waive premiums for remaining Covered Persons for 12 months beginning with the next Premium Due Date following Our receipt of due proof of Your death. During this premium waiver period no increases in benefits or addition of Covered Persons, except newborns, will be considered. All provisions for Loss of Eligibility for Covered Persons will remain applicable during this premium waiver period.
At the end of the 12 months during which premiums were waived, coverage may be continued for Covered Persons by resuming payment of the required premium.

DEFINITIONS

AMBULANCE means a motor vehicle, helicopter, or fixed wing aircraft specially equipped to transport Sick and Injured people. A common carrier is not an Ambulance.

CALENDAR YEAR means the twelve-month period that begins January 1 and ends December 31, each year.

CERTIFICATE means the written description of coverage provided to You as evidence of coverage under the Group Policy.

CERTIFICATE DATE means the date, shown in the Certificate Schedule, when coverage begins for the Covered Persons originally covered under the Group Policy. We use the Certificate Date to determine the anniversary dates of coverage under the Group Policy. It also refers, separately, to the date We add a Covered Person to the Group Policy or when any change in coverage occurs.

CERTIFICATEHOLDER means the Applicant named in the Enrollment Application or any successor thereof named to assume ownership privileges under this Policy. Such person, regardless of title, has exclusive ownership privileges under this Policy. These privileges include, but are not limited to, his/her right to change coverage under this Policy for themselves or any Covered Person.

CLOSE RELATIVE means You or anyone related to You by blood, marriage, or adoption; or a court appointed representative.

COMPLICATIONS OF PREGNANCY means:

1. conditions, requiring Hospital confinement (when the pregnancy is not terminated), whose diagnosis are distinct from pregnancy, but are adversely affected by pregnancy or are caused by pregnancy, such as (1) acute nephritis; (2) nephrosis; (3) cardiac decompensation;(4) HELLP syndrome; (5) uterine rupture; (6) amniotic fluid embolism; (7) chorioamnionitis; (8) fatty liver in pregnancy; (9) septic abortion; (10) placenta accreta; (11) gestational hypertension; (12) puerperal sepsis; (13) peripartum cardiomyopathy; (14) cholestasis in pregnancy; (15) thrombocytopenia in pregnancy; (16) placenta previa; (17) placental abruption; (18) acute cholecystitis and pancreatitis in pregnancy; (19) postpartum hemmorrhage; (20) septic pelvic thromboplebitis; (21) retained placenta; (22) venous air embolus associated with pregnancy; (23) miscarriage; or (24) an emergency c-section required because of (a) fetal or maternal distress during labor, or (b) severe pre-eclampsia, or (c) arrest of descent or dilitation, or (d) obstruction of the birth canal by fibroids or ovarian tumors, or (e) necessary because of the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that, in the absence of immediate medical attention, will result in placing the life of the mother or fetus in jeopardy. A c-section delivery is not considered to be an emergency c-section if it is merely for the convenience of the patient and/or doctor or solely due to a previous c-section; and

2. Treatment, diagnosis or care for conditions, including the following, when the condition was caused by, necessary because of, or aggravated by the pregnancy: (1) hyperthyroidism, (2) hepatitis B 0r C, (3) HIV (4) Human papilloma virus, (5) abnormal PAP, (6) syphilis, (7) chlamydia, (8) herpes, (9) urinary tract infections, (10) thromboembolism, (11) appendicitis, (12) hypothyroidism, (13) pulmonary embolism, (14) sickle cell disease, (15) tuberculosis, (16) migraine headaches, (17) depression, (18) acute myocarditis, (19) asthma, (20) maternal cytomegalovirus, (21) urolithiasis, (22) DVT prophylaxis, (23) ovarian dermoid tumors, (24) biliary atresia and/or cirrhosis, (25) first trimester adnexal mass, (25) hyditidiform mole or (26) ectopic pregnancy.

COVERED PERSON means each person named as a Covered Person on the Certificate Schedule whose coverage under the Group Policy has not terminated.

DOCTOR means a person, other than You or a Close Relative, who is duly licensed to provide the type of medical treatment for which benefits are provided under the Group Policy, and acting within the scope of that license.

EMERGENCY means a medical condition of recent onset and sufficient severity to cause a prudent person to believe that without immediate medical attention the condition may result in:

1. Placing the patient's health in serious jeopardy;
2. Serious impairment to bodily functions;
3. Serious dysfunction of any bodily organ or part;
4. Serious disfigurement; or
5. In the case of a pregnant woman, serious jeopardy to the health of the fetus.

EXPERIMENTAL OR INVESTIGATIONAL MEDICINE means any of the following (generally, individually or collectively, called Regimen) that, when used to treat a Covered Person's specific Injury or Sickness, are experimental, investigational or oriented toward research:

1. Equipment;
2. Drugs or dosages;
3. Devices, services, supplies, tests or medical treatment or procedures; or
4. All related treatment and procedures.

We consider a Regimen as **EXPERIMENTAL OR INVESTIGATIONAL MEDICINE** if:

1. The U.S. Food and Drug Administration (FDA) has not given final approval to the Regimen for the lawful marketing for the treatment of the specific Injury or Sickness; or
2. The American Medical Association (AMA) has not approved or endorsed the Regimen for the treatment of the specific Injury or Sickness; or
3. The National Institutes of Health (NIH) or its affiliated institutes have not approved or endorsed the Regimen for the treatment of the specific Injury or Sickness; or
4. The Regimen is:

    a) Currently used or will be used or studied in proposed or ongoing clinical research or clinical trials as evidenced by the Informed Consent or investigational protocol; or
    b) Part of a proposed or ongoing phase I, II or III clinical trial; or
    c) Subject of proposed or ongoing research or studies to determine its dosage, safety, toxicity, efficacy, or its efficacy as compared to other means of treatment or diagnosis; or

5. The opinion of medical or scientific experts indicates that further studies, research or clinical trials are necessary to determine the Regimen's dosage, safety, toxicity, efficacy or its efficacy as compared to other means of treatment or diagnosis. The opinion of medical or scientific experts is as reflected in:

    a) Published reports or articles in medical or scientific literature; or
    b) Written protocol(s) used by the treating facility or other facilities studying the same or substantially similar Drugs, devices, services, supplies, tests, treatments, or procedures; or
    c) The Informed Consent used by the treating facility or other facilities studying the same or substantially similar Drugs, devices, services, supplies, tests, treatments, or procedures.

We will not exclude a drug for the treatment of cancer because the FDA has not approved the drug for the treatment of the specific type of cancer for which a Doctor has prescribed the drug. However, standard reference compendia or medical literature must recognize the drug for treatment of that specific type of cancer. We will not cover a drug:

1. That the FDA has not approved; or
2. The FDA has contraindicated its use.

HOME HEALTH CARE PLAN means that a licensed Home Health Care Agency provides care and treatment for an Injury or Sickness at a Covered Person's residence. A Doctor must set up and approve a plan in writing.

HOSPICE means an alternative way of caring for terminally ill individuals provided by an entity licensed to provide hospice care for terminally ill individuals and his/her Immediate Families.

HOSPITAL means a facility that:
1. Is licensed as a Hospital in the jurisdiction where it operates; and
2. Provides medical and surgical services for the treatment of Injury or Sickness under the supervision of a Doctor.

The term "Hospital" does not include:

1. A convalescent, nursing, rest or rehabilitative facility; a home for the aged; a special ward, floor or other accommodation for convalescent, skilled nursing, rehabilitation, ambulatory or extended care purposes, including the separate section of a building that houses an acute care facility; hotel units, residential annexes, nurse administered units in or associated with a Hospital; or a psychiatric/substance abuse facility.

2. Any military or veteran's Hospital, soldier's home or any Hospital contracted for or operated by the Federal Government or any agencies thereof for the treatment of members or former members of the Armed Forces, unless the Covered Person is legally required to pay for services in the absence of coverage under the Group Policy.

HOSPITAL CONFINED means that a Covered Person is admitted to a Hospital as an overnight resident bed patient. "Hospital Confined" does not include a Covered Person's treatment in a Same Day Surgery facility, Emergency room, or an observation room.

INJURY (Injured) means accidental bodily injury sustained by the Covered Person, which is the direct cause of loss, independent of disease, bodily infirmity, or any other cause which occurs while coverage under the Group Policy is in force.

INTENSIVE CARE UNIT, CORONARY CARE UNIT OR NEONATAL INTENSIVE CARE UNIT means that part of a Hospital specifically designed as an intensive care unit that is permanently equipped and staffed to provide more extensive care for critically ill or Injured patients than is available in other Hospital rooms or wards. Services provided include close observation by trained and qualified personnel whose duties are primarily confined to the part of the Hospital for which an additional charge is made.

LIMITING AGE for Your children is attained age 26. This is Your coverage anniversary next following the child's 26th birthday.

MEDICALLY NECESSARY means a service or supply necessary and appropriate for the diagnosis or treatment of an Injury or Sickness based upon current generally accepted medical practices. The fact that a Doctor may prescribe, order, recommend, or approve a service or supply does not, of itself, make the service or supply Medically Necessary. A service or supply is not Medically Necessary if:

1. It is provided only as a convenience to the Covered Person or provider;
2. It is not appropriate treatment for the Covered Person's diagnosis or symptoms;
3. It exceeds (in scope, duration, or intensity) that level of care that is needed to provide safe, adequate, and appropriate diagnosis or treatment; or
4. It is Experimental or Investigational Medicine.

MEDICARE means a United States government program set up to provide health care benefits. Medicare includes:

1. The program under Title XVIII of Social Security with any later changes; or
2. Similar programs meant to pay for health care.

MEDICINES OR DRUGS means any medication or medicinal substance that the U.S. Food and Drug Administration has approved for use. The Medicines or Drugs must be used in the Hospital.

MENTAL DISORDER means a disease or disorder, regardless of its cause, that affects the mind or behavior. Categories of mental disorders include mood disorders, anxiety disorders, psychotic disorders, eating disorders, developmental disorders, personality disorders, and other generally accepted disorders of a similar type.

NURSE means any of these:

1. Licensed Registered Nurse (R.N.);
2. Licensed Practical Nurse (L.P.N.);
3. Licensed Vocational Nurse (L.V.N.); or
4. Nurse Practitioner.

"Nurse" does not include a Covered Person or any Close Relative.

ORGAN TRANSPLANT means the placement of tissue or an organ from a live or cadaver donor in a Covered Person. This includes tissue, organ, or cells harvested and returned to the same person, where such tissue or organ is somewhat independent from all other parts of the human body and performs a special or unique function. The source of the tissue, organ, or cells may be from another person. An Organ Transplant does not include the placement of a mechanical or man-made device or substance when the device or substance:

1. Is intended to serve as a substitute for the tissue or organ; or
2. Aids in the performance of the tissue or organ.

An Organ Transplant does not include the grafting of solid tissue or organ such as bone or skin.

PREEXISTING CONDITION means a disease or physical condition of a Covered Person, not otherwise excluded by name or specific description on the date of the Person's loss, which existed prior to the Covered Person's effective date under the Group Policy. Any exclusion or limitation applies only to a disease or physical condition for which medical advice or treatment was received by the Covered Person during the 12 months prior to the effective date of coverage under the Group Policy. In no event will the exclusion or limitation apply to loss incurred after the earlier of:

1. The end of a continuous period of 12 months commencing on or after the effective date of the Covered Person's coverage during all of which the Person received no advice or treatment in connection with such disease or physical condition; or
2. The end of the 2-year period commencing on the effective date of the Covered Person's effective date of coverage under the Group Policy.

REASONABLE AND CUSTOMARY CHARGES means the dollar amount charged that is the lesser of:

1. The actual dollar amount charged;
2. The dollar amount usually charged for the service by the provider who furnishes it; or
3. The prevailing dollar amount charge made for a service in a geographical area made by a facility or person.

SAME DAY SURGERY FACILITY means a licensed medical facility or a part of a Hospital:

1. With an organized staff of Doctors;
2. That is permanently equipped and operated primarily for the purpose of performing surgical procedures;
3. That does not provide accommodations for overnight stays; and
4. That provides continuous Doctor services and nursing services whenever a patient is in the facility.

The term "Same Day Surgery Facility" does not include a:

1. Hospital Emergency room;
2. Trauma center; or
3. Doctor's office or Clinic.

SICKNESS means a Covered Person's illness, disease, or condition that begins after the Certificate Date and while the Covered Person has coverage under the Group Policy. Sickness also includes an illness, disease or condition that begins before the Certificate Date if it is shown on the Enrollment Application and We have not excluded it from coverage by name or specific description. Sickness includes any complications or recurrences that relate to such Sickness while the Group Policy's coverage is in effect for the Covered Person.

US, WE, OUR or THE COMPANY means American National Life Insurance Company of Texas (ANTEX).

YOU or YOUR means the Certificateholder.

BENEFITS

WHAT WE PAY – Benefits are payable under the Group Policy in accordance with Benefit Option A or Benefit Option B, each described below. Each Certificateholder's selected Benefit Option is shown in Your Certificate Schedule. The Benefit Option in effect on January 1st of each year will remain in effect for the remainder of the same Calendar Year. Benefits will not be paid under more than one benefit option during a Calendar Year. All benefits payable under the Group Policy are subject to the Group Policy's Maximum Policy Benefit for each Injury or Sickness per Covered Person. A Covered Person's selected Deductible Amount, Rate of Payment, and Stop Loss Amount are each shown in his/her Certificate Schedule.

BENEFIT OPTION A - Benefits are payable under the Group Policy after a Covered Person incurs charges during a Calendar Year for Medical Services in excess of his/her Deductible Amount. Benefits will be paid at the Rate of Payment. If Your selected Rate of Payment is less than 100%, once charges for Medical Services exceed the Stop-Loss Amount shown in the Certificate Schedule during a Calendar Year, the Rate of Payment for the remainder of the Calendar Year is 100%.

BENEFIT OPTION B - Benefits are payable under the Group Policy after combined charges for Medical Services incurred by one or more Covered Persons during a Calendar Year exceed the Deductible Amount. Benefits will be paid at the Rate of Payment. If Your selected Rate of Payment is less than 100%, once combined unpaid charges for Medical Services incurred by one or more Covered Persons during a Calendar Year exceed the Unpaid Medical Service Charge Maximum shown in Your Certificate Schedule, the Rate of Payment for the remainder of the Calendar Year is 100%. In the event coverage under this Benefit Option B is provided for only one Covered Person, the Deductible Amount shown in Your Certificate Schedule will be reduced by 50%.

UNPAID MEDICAL SERVICES MAXIMUM – This is the maximum amount that You pay each Calendar Year comprised of charges for Medical Services applied to the Deductible Amount and Rate of Payment for Medical Services before We pay 100% of Medical Services charges. There is an Individual or a Family Unpaid Medical Services Maximum depending on whether family coverage is provided. Once Covered Persons have met the Family Unpaid Medical Services Maximum, individually or collectively, We will pay 100% of charges for Medical Services for all Covered Persons for the remainder of the Calendar Year. The Policy Schedule shows Unpaid Medical Services Maximum. **We <u>do not</u> apply the following toward the Unpaid Medical Services Maximum: any non-Medical Service charge, or ineligible expense.**

POLICY MAXIMUM FOR EACH INJURY OR SICKNESS is shown in each Certificateholder's Certificate Schedule. This Maximum applies to each Covered Person.

THE FOLLOWING PROVISIONS DO <u>NOT</u> APPLY IF BENEFIT OPTION B IS IN EFFECT.

FAMILY DEDUCTIBLE MAXIMUM – Once three family members have met their respective Deductible Amounts in a Calendar Year, no further Deductible Amount will be required for the remainder of the Calendar Year.

COMMON ACCIDENT DEDUCTIBLE – If two or more Covered Persons incur Medical Service charges from Injuries sustained in a single accident, We will apply the lesser of:

1. The Deductible Amount;
2. The remainder of each Covered Person's respective Deductible Amount; or
3. The remainder of the Family Deductible Maximum.

VANISHING DEDUCTIBLE AMOUNT – This provision does not apply to a Deductible Amount in excess of $15,000. If coverage under the Group Policy is in effect for a complete Calendar Year and We do not pay any benefits on behalf of any Covered Person, We will reduce the Cash Deductible Amount for the following Calendar Year by 25%. However, We will give no further reductions after the Cash Deductible Amount is reduced to zero. If We pay benefits on behalf of any Covered Person during a Calendar Year, the Cash Deductible Amount for all Covered Persons for the next Calendar Year is the amount shown on the Certificate Schedule. We will extend this provision to any Covered Person added during a Calendar Year during which the Cash Deductible Amount has been reduced.

MEDICAL SERVICES

WE PAY BENEFITS FOR REASONABLE AND CUSTOMARY CHARGES INCURRED FOR THE FOLLOWING MEDICAL SERVICES AT THE APPLICABLE RATE OF PAYMENT. Benefits payable for Medical Services are subject to all terms, limits, and conditions of the Group Policy.

An expense is "incurred" on the date a provider renders the service or furnishes the supplies.

The following are Medical Services under the Group Policy :

Professional Ambulance Service (air or ground) – Reasonable and Customary Charges for transportation to the nearest Hospital qualified to provide for the Covered Person's Medically Necessary Emergency treatment.

Hospital Stay - The Hospital charge for each day a Covered Person is Hospital Confined. Such charge will include those for:

1. Semi-private room confinement, excluding any separate charges such as room, nursing services, maintenance, utilities, and similar items;
2. Intensive Care Unit, Burn Unit, Coronary Care Unit, and Neonatal Intensive Care Unit confinement, up to three times the Hospital's average semi-private room rate; and
3. Medically Necessary miscellaneous services and supplies used for the treatment of the Hospital Confined Covered Person.

Services **DO NOT** include: charges for take-home medicines or drugs, personal or convenience items, or items that are not intended primarily for use while Hospital Confined.

Doctor Visits - Reasonable and Customary Charges for the Covered Person's Doctors' (other than the surgeon) visits when Hospital Confined. For purposes of this provision, a Doctor's consultation is a visit.

Surgery - Reasonable and Customary Charges made by an operating surgeon. If two or more surgeries are performed through the same incision, We will pay the one providing the greatest benefit under the Group Policy. We will also pay [50%] of the benefits otherwise payable for the other surgeries performed through separate incisions during the same operative session. Charges must be incurred while a Covered Person is Hospital Confined or in a Same Day Surgery Facility.

Same Day Surgery Facility - Reasonable and Customary Charges for services provided for a Covered Person by a Same Day Surgery Facility on the day surgery is performed.

If a Covered Person is retained in the Same Day Surgery Facility for more than 18 hours, charges for use of such facility will be limited to the average semi-private room rate consistent with Reasonable and Customary Charges for Hospitals in the area where the Same Day Surgery Facility is located.

Assistant Surgeon - Actual charges for services provided during a surgical procedure by an Assistant Surgeon, up to 25% of the Reasonable and Customary Charge of the primary surgeon. Charges must be incurred while a Covered Person is Hospital Confined or in a Same Day Surgery Facility.

Second Surgical Opinion - Reasonable and Customary Charges for a Doctor providing a second surgical opinion regarding the recommendation for surgery. If the initial and second surgical opinions conflict, We will pay benefits for a third surgical opinion. The Deductible Amount does not apply to a second or third opinion.

Anesthesia Administration - Reasonable and Customary Charges for the administration of anesthesia by an anesthesiologist to a Covered Person undergoing surgery while Hospital Confined or in a Same Day Surgery Facility. The anesthesiologist must be at the operation solely to provide the anesthesia service.

We will reduce benefits otherwise payable had an anesthesiologist administered anesthesia by [50%] if a nurse anesthetist, operating Doctor, or assistant Surgeon administers the anesthesia, including any incidental fluids, as part of a covered surgical procedure. When both an anesthesiologist and a nurse anesthetist bill for the same operative session, benefits will be limited to the Reasonable and Customary charges otherwise payable had the anesthesiologist been the sole provider of such services.

Coverage includes charges incurred for those for services performed in connection with dental procedures in a Hospital or Ambulatory Surgical Center when the Doctor treating the Covered Person certifies that, because of the patient's age or condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the procedures and the Covered Person is: (1) a child under 7 years of age who is determined by two dentists licensed in Arkansas to require, without delay, necessary dental treatment in a Hospital or Ambulatory Surgical Center for a significantly complex dental condition; (2) a person with a diagnosed serious mental of physical condition; or (3) a person with a significant behavioral problem as determined by the Covered Person's Doctor. This benefit does not apply to services performed in connection with temporomandibular joint disorders.

Breast Reconstruction - Reasonable and Customary Charges for the following services and supplies incident to mastectomy:

1. Reconstruction of the affected breast;
2. Reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and physical complications of all stages of mastectomy, including lymphedemas.

Benefits under this coverage will be subject to all the terms and conditions of the Group Policy, except any Exception relating to cosmetic surgery.

Pathology - Reasonable and Customary Charges for pathology services while the Covered Person is Hospital Confined or in a Same Day Surgery Facility. Professional services relating to automated pathology tests are <u>not</u> covered.

Radiology - Reasonable and Customary Charges for radiology services provided for a Covered Person while Hospital Confined or in a Same Day Surgery Facility.

Chemotherapy – Reasonable and Customary Charges for chemotherapy.

Physiotherapy - Reasonable and Customary Charges for physical, speech, occupational, or inhalation therapy. Such therapy must be provided by a Hospital based therapy facility and must result from a Covered Person's treatment in a Hospital or Same Day Surgery Facility.

Radiation Therapy – Reasonable and Customary Charges for radiation therapy.

Home Health Care - Reasonable and Customary Charges for Home Health Care, up to [$7,500] per Calendar Year when a Covered Person receives Home Health Care. The Home Health Care must:

1. Begin within 7 days of a prior Hospital Stay of at least 3 days;
2. Be provided in lieu of a Hospital Stay;
3. Be for services related to the treatment of the same Sickness or Injury for which the Covered Person was Hospital Confined; and
4. Be administered under a Home Health Care Plan.

Hospice Care Benefit - Reasonable and Customary Charges for Hospice Care provided by a licensed Hospice agency. We will not pay benefits under this provision and under another benefit provision of the Group Policy. We only pay benefits for Hospice Care when the Covered Person's Doctor certifies that the Covered Person's life expectancy is less than six months.

Mammogram - Reasonable and Customary Charges in excess of a Covered Person's payment of [$25] for one mammogram per Calendar Year. We pay the benefit whether or not the Covered Person is Hospital Confined. We do not apply such payment to the Deductible Amount or the Rate of Payment.

Foreign Emergency Treatment - We will pay for benefits for Medical Services resulting from charges for Emergency treatment that a Covered Person receives in a foreign country. Benefits payable will be the lesser of: (1) the actual charges for the services; or (2) the benefit for Medical Services that We would have paid if the Covered Person had received the Emergency treatment in the location where the Covered Person resides.

Complications of Pregnancy - If a Covered Person has Complications of Pregnancy while covered under the Group Policy, Medical Services incurred for treatment of such Complications of Pregnancy will be considered for payment as if they had resulted from Sickness. If an expense does not result solely from the treatment of the Complications of Pregnancy, then it will be deemed due to normal pregnancy and not covered under the Group Policy.

Organ Transplant Donor Charges - We will pay donor benefits for covered Organ Transplants:

1. Up to [$15,000] in Medical Services; if
2. You or a Covered Person are legally responsible for the charges.

ARKANSAS RESIDENT BENEFITS – The following benefits apply only when described services are provided to a Covered Person who is an Arkansas resident. Except as otherwise stated, they are subject to all the terms and conditions of the Group Policy.

Newborn Infants – When the Certificate evidences coverage for persons in addition to You, and You have given Us notice of a newborn as required by Automatic Coverage of Newborn and Adopted Children, coverage will include the Reasonable and Customary Charges incurred for the Medically Necessary care and treatment of a newborn child, while the child is Hospital Confined, as follows: (a) coverage for Sickness or Injury, congenital defects, and premature birth; (b) coverage for tests for hypthyroidism, phenylketonuria, galactosemia, sickle-cell amenia, and all other disorders of metabolism for which screening is performed by or for the State of Arkansas, as well as any testing of newborn infants hereafter mandated by law; and (c) a minimum of 48 hours up to 5 full days of routine nursery care and pediatric charges for a well newborn in a Hospital nursery or until the mother is discharged from the Hospital following the birth of the child, whichever is the lesser period of time.

Speech and Hearing - Reasonable and Customary Charges incurred for necessary care and treatment of loss or impairment of speech or hearing while Hospital Confined. Coverage does not include hearing instruments or devices.

Colorectal Screening - Reasonable and Customary Charges for colorectal cancer examinations and laboratory tests, while Hospital Confined or in an Ambulatory Surgical Center, for: (1) Covered Persons who are 50 years of age or older; (2) Covered Persons who are less than 50 years of age and at a high risk for colorectal cancer; (3) Covered Persons experiencing the following symptoms: bleeding from the rectum or blood in the stool; a change in bowel habits, such as diarrhea, constipation, or narrowing of the stool, that lasts more than 5 days.

The colorectal screening will involve an examination of the entire colon, including the following exams or laboratory tests, or both:

1. An annual fecal immunochemical test in conjunction with a flexible sigmoidoscopy every 5 years;
2. A double-contrast barium enema every 5 years; or
3. A colonoscopy every 10 years; and
4. Any additional medically recognized screening tests for colorectal cancer required by the Director of the Department of Health.

Follow-up screenings are covered as follows:

1. If the initial colonoscopy is normal, follow-up is recommended in 10 years;
2. For Covered Persons with 1 or more neoplastic plyps, adenomatous polyps, assuming that the initial colonoscopy was complete to the cecum and adequate preparation and removal of all visualized polyps follow-up is recommended in 3 years;
3. If single tubular adenoma of less than 1 centimeter (4 for patients with large sessile adenomas greater than 3 centimeters) especially if removed in piecemeal fashion, follow-up is recommended in 6 months or until complete polyp removal is verified by colonoscopy.

Diabetes – Reasonable and Customary Charges for equipment, supplies, medication and a one per lifetime self-management training and patient management, including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin-using diabetes, while Hospital Confined. The self-management diabetes training program must be Medically Necessary as determined by a Doctor. Additional training is covered when a Doctor prescribes the additional training as Medically Necessary because of a significant change in the Covered Person's symptoms or conditions.

EXCEPTIONS

WE DO NOT COVER AN INJURY OR SICKNESS THAT IS EXCLUDED BY NAME OR DESCRIPTION.

THE GROUP POLICY DOES NOT PROVIDE COVERAGE FOR LOSS CAUSED BY, CONTRIBUTED TO, OR RESULTING FROM ANY OF THE FOLLOWING EXCEPTIONS:

1. Injury or Sickness if the loss is covered under these or similar laws:
   worker's compensation ,
   employer's liability, or
   occupational disease laws.

2. Injury or Sickness that results from war or an act of war, whether war is declared or not.

3. Care or supplies that a Covered Person receives in a Hospital or other facility that a government agency runs; however, We will not apply this Exception if:

   (a) The Covered Person receives a charge that he/she has to pay by law, and
   (b) The Hospital or facility would have made the charge even if no insurance existed.

4. The diagnosis and/or treatment of the adenoids, tonsils, gallbladder, reproductive organs, and hernia for the first six months of coverage; however, if We have excluded any one of these conditions by rider, We do not pay any benefit for the condition, regardless of when the treatment takes place; or if such condition is a Preexisting Condition, any benefit consideration will be in accordance with the Preexisting Conditions provision; however, this Exception does not apply to a HIPAA Eligible Individual.

5. Procedures or treatments that are Experimental or Investigational Medicine.

6. Pregnancy and childbirth, except for Complications of Pregnancy.

7. Mental Disorders.

8. Cosmetic surgery however, this Exception does not apply when surgery is required:
   a) To correct damage that results from a covered Injury;
   b) To repair a birth defect of a child born to the Certificateholder and continuously covered under this Policy from its birth; or
   c) For breast reconstruction following a covered mastectomy.

9. Breast reduction and surgery to repair, replace, or remove breast implants;

10. Dental Treatment, unless due to Injury to a Covered Person's natural teeth.

11. A Pre-Existing Condition as defined in the Group Policy, except as stated under DEFIITIONS and TIME LIMIT ON CERTAIN DEFENSES, PRE-EXISTING CONDITIONS.

12. Any attempt at suicide, while sane.

13. An intentionally self-inflicted Injury, while sane.

14. A Covered Person's commission of or attempt to commit a felony, an illegal act, or being engaged in an illegal occupation.

15. A Covered Person being intoxicated, unless such intoxication is the result of a prescription drug taken as prescribed by a Doctor.

16. A Covered Person with a blood alcohol concentration equal to or in excess of .08 gms/dl operating any motor vehicle, including any off-road vehicle, or watercraft.

17. Any procedure for refractive correction, eye refraction or the purchase or fitting of vision or hearing aids, Cochlear Implants and related devices.

18. Weight reduction or treatment of obesity, including exogenous, endogenous, or morbid obesity.

19. Mandibular or maxillofacial surgery to correct growth defects and jaw disproportions or malocclusions; increase vertical dimension; or reconstruct occlusion after one year from a child's date of birth or a child's date of adoption, except where such surgery is for the repair of a congenital anomaly or birth defect of a child born to You or a child that he/she adopts if the child is continuously covered from birth, adoption, or placement for adoption.

20. Treatment provided outside the United States of America, its possessions and territories, except as otherwise provided under Foreign Emergency Treatment.

21. Diagnosis or treatment (including surgery) of sexual dysfunction disorder or inadequacy; or transsexual surgery.

22. Sclerotherapy for veins of the extremities or laser surgery to minimize veins.

23. Routine newborn care.

24. Care in a nursing home or custodial institution; domiciliary care or rest cures.

25. Charges for Medical Services that You or a Covered Person is not legally obligated to pay.

26. Any charges for or relating to: artificial insemination; in-vitro fertilization or any other diagnosis or treatment for the control, promotion, or enhancement of fertility; treatment for impotency; sterilization or reversal of prior sterilization; abortion, unless the life of the mother would be endangered if the fetus were carried to term; or therapeutic abortion.

27. Drugs and supplies provided for home use.

28. Treatment of alcoholism or drug use.

29. False labor; pre-term or premature labor; occasional spotting; prescribed rest while pregnant; morning sickness; hyperemesis gravidarum; or pre-eclampsia. There may be other conditions that relate to a difficult pregnancy that a Doctor can manage.

AUTOMATIC COVERAGE OF NEWBORN AND ADOPTED CHILDREN

Newborns: If the Group Policy provides coverage for Covered Persons other than You, the Policy will also provide coverage for newborn children when they live with You from the moment of birth. This coverage is free for the first 90 days.

Adopted Children: If the Group Policy provides coverage for Covered Persons other than You, the Policy will also provide coverage for adopted children and children who are placed for adoption from the date of the filing of a petition for adoption. This coverage for adopted children is free for the first 60 days of the filing of a petition for adoption if You apply for coverage within 60 days after the filing of the petition for adoption. However, the coverage will be free for the first 60 days from the moment of birth if the petition for adoption and application for coverage is filed within 60 days after the birth of the minor.

In order to continue coverage for a newborn or adopted child, You must do the following:

1. Send Us notice of the child within the 90 days after the date of the child's birth or before the premium due date, whichever is later (or, in the case of an adopted child, within the 60 days after the filing of the petition for adoption or birth of child); and
2. Send Us the additional premium for the child within 90 days of the child's date of birth or within 60 days of the date of petition for adoption or birth of the child.

As long as You pay the extra premium, the child will remain a Covered Person, subject to the Termination of Coverage and Loss of Coverage Eligibility provisions of the Group Policy. Coverage for a child that is placed with You for adoption will continue in accordance with the Termination of Coverage and Loss of Coverage Eligibility provisions, unless the placement is disrupted prior to legal adoption and the child is removed from placement.

We do not require an application for the child unless You have notified Us of the child later than the ~~31 days~~ timeframe as required above.

TERMINATION OF COVERAGE

We can terminate coverage under the Group Policy as of any premium due date under any of the following conditions:

1. You have failed to pay premiums or contributions in accordance with the terms of the Group Policy, or We have not received timely premium payments;
2. You or a Covered Person has performed an act or practice that constitutes fraud with respect to activities under the Group Policy;
3. You no longer reside, live, or work in the PPO service area or in an area where We have authority to do business. We will only apply this provisions if We end coverage uniformly and without regard to any health status related factor of a Covered Person; or
4. We are ceasing to offer coverage in the medical expense market in accordance with applicable state law.

Notice of termination will be provided in accordance with state law.

If coverage under the Group Policy ends and is replaced by a group health insurance plan issued by another insurer or self-funded health care plan, coverage under the Group Policy will continue for any Covered Person who is Hospital Confined on the date coverage under the Group Policy ends. Continuation of such benefits are subject to all terms and conditions the Group Policy, except those relating to termination of benefits. Such benefits will continue until the Hospital Confinement ends or until the maximum benefits available under the Group Policy are paid, whichever occurs first.

Subject to the conditions listed above, We cannot refuse to renew coverage:

1. Just because of a change in a Covered Person's health or the type of work the Covered Person performs; or
2. Just because of the claims filed by or on behalf of a Covered Person, unless the claims are fraudulent.

LOSS OF ELIGIBILITY

Eligibility for continuation of coverage under the Group Policy by a Covered Person ends on the date of the month that coincides with the date of the month shown on the Certificate Schedule and occurs on such date next following the date of the event that causes such termination. If a Covered Person's coverage ends under the Group Policy, in accordance with the paragraphs above, such Person may be eligible for Continuation or Conversion. Please see the Conversion Privilege and the State Continuation Privilege.

RULES FOR ALL COVERED PERSONS - Coverage will end:

1. If the Group Policy is terminated in accordance with the section titled TERMINATION OF COVERAGE; or
2. If You fail to pay the required premium within the time the Grace Period.

RULES FOR ADULT COVERED PERSONS - Coverage will end:

1. For Your spouse if there is a divorce; or
2. If a mentally or physically disabled Covered Person marries or becomes capable of self-support. (See the section titled EXTENSION OF COVERAGE FOR SOME CHILDREN).

If a married Certificateholder dies and his/her spouse is a Covered Person, the spouse will become the Certificateholder.

RULES FOR CHILD COVERED PERSONS - Coverage will end for a child when:

1. The child is no longer a dependent of You;
2. The child gets married; or
3. The child attains the Limiting Age, except for the extension allowed by the section titled EXTENSION OF COVERAGE FOR SOME CHILDREN.

PREMIUM – We will adjust premiums if required under Our rules as of the date coverage ends for a Covered Person. This will occur on a date consistent with the date coverage ends, as described above.

SUCCESSION – If the Certificateholder dies and is survived by other Covered Persons, a new Certificateholder will be named in accordance with the following:

1. If the deceased Certificateholder was married at the time of death and his/her spouse is a Covered Person, the spouse will become the new Certificateholder;

2. If the deceased Certificateholder was married at the time of death and his/her spouse is <u>not</u> a Covered Person, while other Covered Persons survive the deceased Certificateholder, the spouse will become the Certificateholder; or

3. If the deceased Certificateholder was unmarried at the time of death while other Covered Persons survive the deceased Certificateholder, the estate of the deceased Certificateholder shall be entitled to name a new Certificateholder in accordance with the Company's rules in effect on the date of the deceased Certificateholder's death.

EXTENSION OF COVERAGE FOR SOME CHILDREN

When an unmarried dependent child who is a Covered Person has reached the Limiting Age, coverage may continue if the child is, and remains, incapable of sustaining employment by reason of mental retardation or physical disability and who is chiefly dependent upon You for support and maintenance.

ANTEX may ask You to furnish proof of the incapacity or dependency. ANTEX will bear the cost of obtaining such proof. You are expected to notify ANTEX if the incapacity or dependency is removed or terminated in the future.

The premium rate for the handicapped dependent will remain at the child rate.

TOTAL DISABILITY

"Total Disability" means a Covered Person's inability, because of Sickness or Injury, to perform the material and substantial duties of his/her occupation.

If a Covered Person suffers from Total Disability at the time of any termination or discontinuance of this Policy by ANTEX, regardless of the reason for the termination or discontinuance, ANTEX will provide an extension of benefits for a period of 12 months immediately following the date of termination or discontinuance. Benefits payable will be subject to this Policy's regular benefit limits.

CONVERSION PRIVILEGE

If coverage under the Group Policy has been terminated, Covered Persons are entitled to have a conversion policy issued by ANTEX, without evidence of insurability, subject to the following terms and conditions:

1. A conversion policy is not available to a Covered Person if termination of his insurance under the Group Policy occurs:
   a) Because he/she failed to make timely payment of any required premium; or
   b) Because the Group Policy terminated and the insurance was replaced by similar coverage under another group policy within thirty-one (31) days of the date of termination; and

2. Written application and the first premium payment for the conversion policy shall be made to ANTEX not later than thirty-one (31) days after such termination.

The premium for the conversion policy shall be determined in accordance with ANTEX's table of premium rates applicable to the age and class of risk of each person to be covered under that policy and to the type and amount of insurance provided.

The conversion policy shall cover the Covered Persons on the date his/her coverage terminates under the Group Policy. At the option of ANTEX, a separate conversion policy may be issued to cover any dependent. ANTEX shall not be required to issue a conversion policy covering any person if such person is or could be covered by Medicare. Furthermore, ANTEX shall not be required to issue a conversion policy covering any person if:

1. Such person is or could be covered for similar benefits under an individual policy; such person is or could be covered for similar benefits under any arrangement of coverage for an individual in a group, whether insured or uninsured; or similar benefits are provided for or available to such person by reason of any state or federal law; and

2. The benefits under sources described in paragraph (1) above for such person, or benefits provided or available under sources described in paragraph (1) above for such person, together with the conversion policy's benefits would result in overinsurance according to ANTEX's standards for overinsurance.

The conversion policy will not exclude, as a Pre-Existing Condition, any condition covered by the Group Policy; provided, however, that the conversion policy may provide for a reduction of its hospital, surgical, or medical benefits by the amount of any such benefits payable under the Group Policy after the individual's insurance terminates.

STATE CONTINUATION PRIVILEGE

If coverage ends under the Group Policy for certain reasons, a Covered Person may be able to continue his coverage.

CONTINUATION:

A Covered Person may continue his coverage under the Group Policy and that of his dependents who are covered under the Group Policy if his coverage would otherwise end because of termination of membership or because of a change in marital status. Such coverage will be continued if the person:

1. Has been continuously covered under the Group Policy for the 3 month period prior to termination of membership or change in marital status; and

2. Is not eligible for Medicare or is not fully covered (i.e., all Pre-Existing Conditions are covered) under any other group medical policy or contract;

Continuation will be allowed under this provision until all Pre-Existing Conditions are covered or would be covered under another group policy or contract or until termination pursuant to this continuation provision or pursuant to any applicable provision of federal law.

To continue coverage, the person must request continuation in writing within 10 working days of termination of membership or change in marital status. Premiums must be p[aid on a monthly basis in advance in accordance with the terms of the Group Policy.

This continuation will end on the earliest of the following dates:
1. 120 days from the date continuation began;
2. The end of the period for which premiums are paid on a timely basis;
3. The premium due date following the date the person becomes eligible for Medicare;
4. The date maximum benefits available under the Group Policy are paid for such person; or
5. The date of termination of the Group Policy; however, continuation will continue under any replacement policy.

Upon termination of this continuation, the person may have the right of conversion described above. Any person who elects the conversion privilege waives the right to this continuation.

COORDINATION OF BENEFITS

The Coordination of Benefits (COB) provision applies when a Covered Person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans does not exceed 100% of the total Allowable expense.

DEFINITIONS

A. A **Plan** is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts:

(1) **Plan** includes: group and nongroup insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

(2) **Plan** does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

B. **"This Plan"** means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. The order of benefit determination rules determine whether This plan is a Primary plan or Secondary plan when the Covered Person has health care coverage under more than one Plan.

When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

D. Allowable expense is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the Covered Person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering the Covered Person is not an Allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered Covered Person is not an Allowable expense.

The following are examples of expenses that are not Allowable expenses:

(1) The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.

(2) If a Covered Person is covered by 2 or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.

(3) If a Covered Person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.

(4) If a Covered Person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary plan's payment arrangement shall be the Allowable expense for all Plans. However, if the provider has contracted with the Secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary plan to determine its benefits.

(5) The amount of any benefit reduction by the Primary plan because a Covered Person has failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

E. Closed panel plan is a Plan that provides health care benefits to Covered Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

F. Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When a Covered Person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

A. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.

B. (1) Except as provided in Paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary.

(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide out-of-network benefits.

C. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

D. Each Plan determines its order of benefits using the first of the following rules that apply:

(1) Non-Dependent or Dependent. The Plan that covers the Covered Person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary plan and the Plan that covers the Covered Person as a dependent is the Secondary plan. However, if the Covered Person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the Covered Person as a dependent; and primary to the Plan covering the Covered Person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the Covered Person as an employee, member, policyholder, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.

(2) Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

(i.) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or
(ii.) If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.

(b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(i.) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
(ii.) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;
(iii.) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or
(iv.) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

1. The Plan covering the Custodial parent;
2. The Plan covering the spouse of the Custodial parent;
3. The Plan covering the non-custodial parent; and then
4. The Plan covering the spouse of the non-custodial parent.

(c) For a dependent child covered under more than one Plan of individuals who are the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

(3) Active Employee or Retired or Laid-off Employee. The Plan that covers a Covered Person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same Covered Person as a retired or laid-off employee is the Secondary plan. The same would hold true if a Covered Person is a dependent of an active employee and that same Covered Person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(4) COBRA or State Continuation Coverage. If a Covered Person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the Covered Person as an employee, member, subscriber or retiree or covering the Covered Person as a dependent of an employee, member, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(5) Longer or Shorter Length of Coverage. The Plan that covered the Covered Person as an employee, member, policyholder, subscriber or retiree longer is the Primary plan and the Plan that covered the Covered Person the shorter period of time is the Secondary plan.

(6) If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This plan will not pay more than it would have paid had it been the Primary plan.

EFFECT ON THE BENEFITS OF THIS PLAN

A. When This plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary plan. The Secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim. In addition, the Secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If a Covered Person is enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed panel plan, COB shall not apply between that Plan and other Closed panel plans.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This plan and other Plans. ANTEX may get the facts it needs from or give them to other organizations or Covered Persons for the purpose of applying these rules and determining benefits payable under This plan and other Plans covering the Covered Person claiming benefits. ANTEX need not tell, or get the consent of, any person to do this. Each Covered Person claiming benefits under This plan must give ANTEX any facts it needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another Plan may include an amount that should have been paid under This plan. If it does, ANTEX may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This plan. ANTEX will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by ANTEX is more than it should have paid under this COB provision, it may recover the excess from one or more of the Covered Persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the Covered Person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

GENERAL PROVISIONS

ENTIRE CONTRACT -- The Entire Contract will consist of:

1. The Group Policy;
2. The Application of the Group Policyholder, which will be attached to the Group Policy;
3. Any Enrollment Applications and attached papers for the proposed Covered Persons; and
4. Any riders, endorsements or amendments issued with or added to the Group Policy or any Certificate which is a part of the Group Policy.

We will deem all the statements provided in the Enrollment Application and attached supplements, except fraudulent statements, as representations and not warranties.

TIME LIMIT ON CERTAIN DEFENSES --

1. MISSTATEMENTS IN THE ENROLLMENT APPLICATION --
We may only use fraudulent misstatements in the Enrollment Application to void coverage under the Group Policy or to deny any claim for loss incurred more than 24 months after the Covered Person's Certificate Date.

2. PRE-EXISTING CONDITIONS --
No claim for loss incurred after the earlier of: (a) the end of a continuous period of 12 months commencing on or after the Covered Person's effective date of coverage under the Group Policy, during which the Covered Person has received no medical advice or treatment in connection with such disease or physical condition or (b) the end of the 2-year period commencing on the effective date of the Covered Person's coverage under the Group Policy will be reduced or denied unless:

(a) The disease or physical condition has been excluded from coverage by name or specific description, and;
(b) Such exclusion is in effect on the date the loss is incurred.

REINSTATEMENT -- Coverage terminates if You do not pay a periodic premium payment before the end of the Grace Period. Our later acceptance of premium, (or one of our authorized agent's acceptance of premium) without requiring an application for reinstatement, reinstates coverage under the Group Policy.

We will require an application for reinstatement. We will subject all representations made in this application to all of the provisions of the Group Policy, including TIME LIMIT ON CERTAIN DEFENSES. If We approve the application for reinstatement, We will reinstate coverage as of the approval date of the reinstatement Enrollment Application. If We do not approve the reinstatement and do not notify You in writing of the disapproval, We must reinstate coverage. The reinstatement will take place on the 45th day following the date of Our receipt of the application for reinstatement.

The reinstated plan only covers loss resulting from:

1. Injury that occurs after reinstatement; and
2. Sickness that begins ten days or more after the Covered Person's date of reinstatement.

In all other respects, the Covered Person's rights and Our rights will remain the same, except as stated in any application attached to the reinstated coverage.

We will apply any premiums that We accept for reinstatement to a period for which You have not paid premiums. We will not apply any premium to any period more than 60 days before the reinstatement date.

WE WILL NOT CONSIDER A REQUEST FOR REINSTATEMENT THAT YOU MAKE MORE THAN 180 DAYS AFTER COVERAGE UNDER THE GROUP POLICY HAS TERMINATED.

GRACE PERIOD -- There is a 31 day grace period for the payment of any premium. If a renewal premium is not paid on or before its due date, it may be paid during the following 31 days. If We do not receive the payment during this Grace Period, We will terminate coverage. Termination will be effective as of the end of the period for which

premium was paid. The Grace Period does not apply if the Company has provided a notice of intent to terminate the Group Policy.

NOTICE OF CLAIMS -- A claimant must give notice of claim within 30 days after a covered loss starts or as soon as reasonably possible. The claimant must give the notice to Us at Our Home Office in Galveston, Texas. The notice must include the claimant's name and his/her Certificate Number.

CLAIM FORMS -- When We receive notice of claim, We will send the claimant forms for filing Proof of Loss. If We do not mail the claimant these forms within 15 days of Our receipt of his/her request, the claimant will have met the Proof of Loss requirement. However, the claimant must still give Us a written statement of the nature and extent of the loss within the time limit stated in the Proof of Loss section.

PROOFS OF LOSS -- The claimant must give written Proof of Loss to the Home Office in Galveston, Texas within 90 days after such loss. If it was not reasonably possible for the claimant to give the Proof of Loss in the time required, We will not reduce or deny the claim as long as the claimant gives proof as soon as reasonably possible. In any event, the claimant must give proof no later than 1 year from the time specified, unless the claimant was legally incapacitated.

TIME FOR PAYMENT OF CLAIMS -- All benefits payable under the Group Policy will be paid immediately upon receipt of Proof of Loss.

We will pay or deny each Clean Claim as follows: (1) if the claim is filed electronically, within 30 days after the date We receive the claim; or (2) if the claim is filed on paper, within 45 days after the date we receive the claim. We will notify the claimant of any deficiencies in the claim not less than 30 days after the date We receive the claim. The notice will give an explanation of any additional information required. We will suspend the claim until We receive the requested information. We will reopen and pay or deny the suspended claim within 30 days after We receive the information requested..

If We fail to pay or deny a Clean Claim or to give notice that We need more information to pay a claim, We will pay the claimant for the period beginning on the 61st day after receipt of the Clean Claim and ending on the Clean Claim payment date (this is called the delinquent payment period), calculated as follows: the amount of the Clean Claim payment times 12% per annum times the number of days in the delinquent payment period, divided by 365. We will pay this penalty without any action by the claimant.

A "Clean Claim" means a claim for payment of health care expenses that is submitted on a HCFA 1500 on a UB92 in a format required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), or on Our standard claim form with all required fields completed in accordance with Our published claim filing requirements. A Clean Claim does not include a claim (1) for payment of expenses incurred during a period of time for which premiums are delinquent; or (2) for which We need additional information in order to resolve the claim.

PAYMENT OF CLAIMS -- We will pay Group Policy benefits to You. If You have assigned benefits, We will pay the benefits to the respective assignee. If You have died, We will pay any unpaid benefits to Your estate. We may pay benefits up to [$1,000] to someone related to You by blood or marriage or to any other person We deem entitled to the benefits if:

1. A court has deemed You incompetent; or
2. You have died and Your estate is not able to execute a valid release.

NO ASSUMPTION OF LIABILITY -- Our payment of any claim does not mean We have assumed liability for future payments for the same condition or any related condition once:

1. We determine that no Medical Service charges exist; or
2. We determine that Our payment was erroneous or inappropriate.

PHYSICAL EXAMINATIONS -- We have the right to have any Covered Person examined as often as reasonably required while a claim is pending for that person. We will pay for the requested physical examination.

LEGAL ACTIONS -- No legal action may be brought to recover on the Group Policy within 60 days after a claimant gives written Proof of Loss. No legal action may be brought after 3 years from the time the Group Policy requires written proof of loss.

LIMITATION OF LIABILITY: You agree that Our liability arising under the Group Policy or in any way related to it is limited to:

(a) Group Policy benefits otherwise payable;
(b) Your reasonable attorneys fees, if any; and
(c) Any statutory penalties that may be imposed.

TERMINATION OF THE GROUP POLICY -- ANTEX or the Group Policyholder may terminate the Group Policy, as described under **TERMINATION OF COVERAGE**, provided written notice is provided 31 days in advance to the other party.

MISSTATEMENTS OF AGE -- If a Covered Person has misstated his/her age, the benefits will be those the premium paid would have purchased if the correct age had been disclosed. However, if on the Certificate Date, We would not have granted coverage because of the Covered Person's correct age, We are only liable for the return of any premiums paid on account of such person.

CONFORMITY WITH STATE STATUTES -- Any provision of the Group Policy which, on the Certificate Date, is in conflict with the laws of the state in which You reside on that date is amended to conform to the minimum requirements of the laws of the state.

ILLEGAL OCCUPATION -- We will not be liable for any loss that results from a Covered Person engaging in an illegal occupation or committing or attempting to commit a felony.

ASSIGNMENT -- No assignment of interest under the Group Policy will be binding upon ANTEX unless and until We receive the original or a duplicate of the assignment at Our Home Office in Galveston, Texas. Any assignment will be subject to any right of offset that We may be entitled to assert. We are not responsible for the validity or sufficiency of any assignment. If We pay the assignor, We are not liable for payment to the assignee.

AUTHORITY, AMENDMENT, AND ALTERATION -- Neither ANTEX nor the Group Policyholder may modify any terms of the Group Policy except by a written agreement signed by one of Our officers. Neither ANTEX nor the Group Policyholder may waive any forfeiture under the Group Policy except by a written agreement signed by one of Our officers. ANTEX may not delegate the authority for the purposes of this provision. ANTEX may amend or change the Group Policy at any time, subject to the laws of the jurisdiction in which We delivered the Group Policy. In this case, We may amend or change the Group Policy by written agreement between the Group Policyholder and Us and without the consent of the Covered Persons or his/her beneficiaries, if any. No agent has the authority to waive an answer to any question in the application, determine insurability, make or alter any contract or waive any of ANTEX's other rights or requirements. No change in the Group Policy will be valid unless evidenced by endorsement on the Group Policy or by a signed amendment to the Group Policy.

ELECTRONIC ACCOUNT DEBIT AUTHORIZATION -- If You have chosen Electronic Account Debit as Your method of payment, You agree that:

1. We are authorized to debit Your named account for required payments;
2. The account debit will be made electronically without the signature of any officer or employee of ANTEX;
3. We will not provide a receipt for any account debit;
4. ANTEX will not incur any liability because of dishonor of the account debit;
5. Upon refusal of the financial institution to honor any attempted debit of the named account, We will cease to debit Your account. We will send You written notice requesting payment in full of the required premium. Upon Your payment of the required premium, We will again begin to debit Your account. However, if You do not pay the required premium, Your coverage will lapse in accordance with the Grace Period provision; and
6. Except as provided in (4) above, the authorization remains effective unless either party ends the authorization. Before ending the authorization, a party must provide the other party at least 30 days advance written notice. We are not liable for amounts debited from Your account prior to Our receipt of written notification to end coverage.

DIRECT PAYMENT TO PUBLIC HOSPITALS AND CLINICS -- Benefits to a Covered Person shall be paid, with or without an assignment from the Covered Person, to public Hospitals or clinics for services and supplies provided to the Covered Person if a proper claim is submitted by the public Hospital or clinic. No benefits shall be paid under this provision to the public Hospital or clinic if such benefits have been paid to the Covered Person prior to receipt of the claim by ANTEX. Payment to the public Hospital or clinic of benefits pursuant to this provision shall discharge ANTEX from all liability to the Covered Person to the extent of the benefits so paid. Nothing in this provision shall be construed to require payment of benefits for the same services or supplies to both the Covered Person and the public Hospital or clinic.

NOTICE TO CERTIFICATEHOLDERS: We are here to serve the Certificateholder. As our Certificateholder, Your satisfaction is very important to Us. If You have a question about Your Certificate, if You need assistance with a problem, or if You have a claim, You should first contact Your insurance agent or Us at 1-800-899-6520. If You do not have Your agent's name, address, or phone number, please contact Us and We will be able to supply the information.

If We at ANTEX fail to provide You with reasonable and adequate service, You should feel free to contact:

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, AR 72201-1904
1-800-852-5494

EXTERNAL REVIEW PROCEDURE – In certain cases, the Certificateholder has the right to request an External Review Procedure, as described in this Section.

The following terms are defined:

Adverse Determination means the Company's determination that an admission, availability of care, continued stay or other Medical Service has been reviewed and, based upon the information provided, the requested payment for the service is denied, reduced or terminated, because:

(a) The requested Health Care service does not meet the Company's requirements for Medical Necessity, or
(b) The requested Health Care service has been found to be "Experimental/Investigational."

In order to qualify as an "Adverse Determination:"

(a) The Adverse Determination must be a Final Adverse Determination, except as may be provided herein.
(b) The Adverse Determination must involve treatment, services, equipment, supplies, or drugs that would require the health benefit plan to expend five hundred dollars ($500) or more of expenditures.

Adverse Determination does not include the Company's determination to deny a Health Care service based upon:

(a) An express exclusion in the health benefit plan other than a general exclusion for "Medical Necessity" or "Experimental/Investigational;"
(b) An express limitation in the health benefit plan with respect to the number of visits, treatments, supplies or services for a covered benefit in a given calendar period or over the lifetime of the Covered Person;
(c) An express limitation in the health benefit plan with respect to a maximum dollar limitation with respect to a covered benefit in a given calendar period or over the lifetime of the Covered Person;
(d) the Company's determination that an individual is not eligible to be a Covered Person;
(e) the Company's determination that treatment, service, or supplies were requested or obtained by a Covered Person through fraud or material misrepresentation.
(f) The health benefit plan's procedure for determining the Covered Person's access to a Health Care Provider, including but not limited to a network access provision;
(g) Illegality of services or the means or methods of administering them;
(h) FDA or other government agency determinations, reports or statements; or
(i) Licensure, permit or accreditation status of a Health Care Provider.

Authorized Representative means:

(a) A person to whom a Covered Person has given express written consent to represent the Covered Person in an External Review;
(b) A person authorized by law to provide substituted consent for a Covered Person; or
(c) When the Covered Person is unable to provide consent, a family member of the Covered Person or the Covered Person's treating Health Care Professional if a family member is unavailable.

Commissioner means the Arkansas Insurance Commissioner.

Covered Benefits or Benefits means those Health Care services to which a Covered Person is entitled under the terms of a health benefit plan.

Covered Person means You. Covered Person shall also mean the Covered Person's Authorized Representative, as defined in this regulation.

Disclose means to release, transfer or otherwise divulge protected Health Information to any person other than the individual who is the subject of the protected Health Information.

Emergency Medical Condition means medical conditions of a recent onset and severity, including, but not limited to, severe pain that would lead a prudent lay person, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

Emergency Services means Health Care items and services furnished or required to evaluate and treat an Emergency Medical Condition.

External Review means a process, independent of all affected parties, to determine if a Health Care service is medically necessary or experimental/ investigational.

Facility means an institution providing Health Care services or a Health Care setting, including but not limited to, hospitals and other licensed inpatient centers, outpatient surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

Final Adverse Determination means an Adverse Determination involving a covered benefit that has been upheld by a health carrier at the completion of the health carrier's internal grievance procedure or Utilization Review procedure. If the health carrier does not have, nor is required by law to have, an internal grievance procedure or Utilization Review procedure, an Adverse Determination shall be considered a Final Adverse Determination.

Health care professional means a physician or other Health Care practitioner licensed, accredited or certified to perform specified health services consistent with state law.

Health Care Provider or Provider means a Health Care Professional or a Facility.

Health Care Services means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.

Health Information means information or data, whether oral or recorded in any form or medium, and personal facts or information about events or relationships that relates to:

(a) The past, present or future physical, mental, or behavioral health or condition of an individual or a member of the individual's family;

(b) The provision of Health Care services to an individual; or

(c) Payment for the provision of Health Care services to an individual.

Independent Review Organization means an entity that conducts independent External Reviews of Adverse Determinations and Final Adverse Determinations.

Medical or Scientific Evidence means the following sources:

(a) Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;
(b) Peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the National Institutes of Health's Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline and MEDLARS database Health Services Technology Assessment Research (HSTAR);
(c) Medical journals recognized by the Secretary of Health and Human Services under Section 1861(t)(2) of the federal Social Security Regulation;

(d) The following standard reference compendia: The American Hospital Formulary Service-Drug; The American Dental Association Accepted Dental Therapeutics; and The United States Pharmacopoeia-Drug Information;

(e) Findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including: The federal Agency for Healthcare Research and Quality; The National Institutes of Health; The National Cancer Institute; The National Academy of Sciences; The Centers for Medicare and Medicaid Services; Any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of Health Care services; and Any other Medical or Scientific Evidence that is comparable to the sources listed in Subparagraphs (a) through (e).

Medical or Scientific Evidence shall not include published peer-reviewed literature sponsored to a significant extent by a pharmaceutical manufacturing company or medical device manufacturer.

Medically Necessary or Medical Necessity has the same definition as found under the section of the Certificate titled **DEFINITIONS.**

Person means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, a limited liability company, any similar entity or any combination of the foregoing.

Protected Health Information means Health Information that is not subject to disclosure under state and/or federal law.

Retrospective Review means a review of Medical Necessity conducted after services have been provided to a patient, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication for payment.

Utilization Review and Utilization Review Procedure mean the system for reviewing the appropriate and efficient allocation of hospital resources and medical services given or proposed to be given to a patient or group of patients.

Requesting an External Review, General Information - At the time of an Adverse Determination or a Final Adverse Determination, the Company will notify the Covered Person and Health Care Professional in writing of the right to request an External Review.

Before filing a request for an External Review, a Covered Person must exhaust the Company's internal grievance procedures (unless the Company waives this requirement). A Covered Person has exhausted the internal grievance procedure when:

(a) The Covered Person has filed an appeal regarding an Adverse Determination with the Company; and
(b) The Covered Person has not received a written decision on the appeal from the Company within 30 days following the date the Covered Person filed the appeal. (This 30 day requirement does not apply if the Covered Person requested or agreed to a delay of the 30 day requirement); or
(c) The Covered Person has received a written decision regarding the appeal and the Company has made a Final Adverse Determination.

Once the Covered Person has received a Final Adverse Determination, the Covered Person has 60 days to request of External Review. The Covered Person must request an External Review in writing.

When requesting an External Review, the Covered Person will be required to authorize the release of any medical records that may be required for review in making the decision on the External Review. the Company will attach the authorization form to the External Review Notice.

A Covered Person has the right to contact the Commissioner for assistance with the External Review process at any time. The Commissioner's contact information is:

Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201
(501)371-2600 or 1-800-282-9134
insurance.Consumers@Arkansas.gov

Standard External Review – When the Company receives a request for an External Review, it will assign an Independent Review Organization (IRO) to the External Review.

The IRO will conduct a preliminary review to determine if:

(1) The request meets External Review requirements;
(2) The Covered Person has exhausted the Company's internal grievance process (unless the Covered Person is not required to exhaust the grievance process as described in this notice); and
(3) The Covered Person has provided all information and forms required to process an External Review, including the authorization form that the Company provided at the time of the Adverse or Final Adverse determination.

Within 5 business days, the IRO will review the Request and notify the Covered Person whether the request is complete and whether the IRO has accepted the Request. Within 7 business days after the date of receipt of this IRO notice, the Company will provide to the IRO, the Covered Person, and the Covered Person's treating Health Care Professional the documents and any information considered in making the Adverse Determination or Final Adverse Determination, together with any additional information required.

The IRO notice will include a statement that the Company, the Covered Person and the Covered Person's treating Health Care Professional may submit additional information and supporting documentation in writing to the IRO within 7 business days following the date of receipt of the notice. The IRO will consider this information when conducting the External Review. The IRO shall review all of the information and documents received in writing by the Covered Person, the Covered Person's treating Health Care Professional, and the Company.

If the request is not complete, the assigned IRO will, within 5 business days, inform the Company, the Covered Person, and the Covered Person's treating Health Care Professional what information or materials are needed to make the request complete. The IRO will immediately forward copies of any additional information to the Company.

If the request is not accepted for External Review, the assigned IRO will inform the Covered Person, the Covered Person's treating Health Care Professional and the Company in writing within 5 business days of the reasons for its nonacceptance.

In reaching a decision to accept or reject a matter for External Review, the IRO is not bound by any decisions or conclusions reached during the Company's internal grievance procedure or Utilization Review procedure.

Except in the case of the IRO terminating and reversing the Company's Adverse Determination or Final Adverse Determination because the Company failed to provide documents and information to the IRO within an acceptable time frame, failure by the Company or its Utilization Review organization to provide the documents and information within the time frame required will not delay the conduct of the External Review.

If the Company or its Utilization Review Organization fails to provide the documents and information within the time frame required, the IRO may terminate the External Review and make a decision to reverse the Adverse Determination or Final Adverse Determination.

Upon receipt of the information, if any, required to be forwarded to the IRO, the Company may reconsider its Adverse Determination or Final Adverse Determination that is the subject of the External Review.

Reconsideration by the Company of its Adverse Determination or Final Adverse Determination will not delay or terminate the External Review.

The External Review may only be terminated if the Company decides, upon completion of its reconsideration, to reverse its Adverse Determination or Final Adverse Determination and provide coverage or payment for the Health Care service that is the subject of the Adverse Determination or Final Adverse Determination.

Immediately upon making the decision to reverse its Adverse Determination or Final Adverse Determination, the Company shall notify the Covered Person, the Covered Person's treating Health Care Professional, and the IRO in writing of its decision.

The IRO will terminate the External Review upon receipt of the notice from the Company regarding its reversal.

In addition to the documents and information referred to above, the IRO, to the extent the information or documents are available and the IRO considers them appropriate, shall consider the following in reaching a decision:

(1) The Covered Person's medical records;
(2) The treating Health Care Professional's recommendation;
(3) Consulting reports from appropriate Health Care Professionals and other documents submitted by the health carrier, Covered Person, or the Covered Person's treating Health Care Professional;
(4) The most appropriate practice guidelines, which may include generally accepted practice guidelines, evidence-based practice guidelines or any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;
(5) Any applicable written screening procedures, decision abstracts, clinical protocols and practice guidelines used by a health carrier to determine the necessity and appropriateness of Health Care services;
(6) If the Adverse Determination involves a denial of coverage based on a determination that the recommended or requested Health Care services is "experimental" or "investigational," the IRO shall also consider whether:
    (a) The recommended or requested Health Care service or treatment has been approved by the federal Food and Drug Administration for the condition, while realizing that treatments or services are often legitimately used for purposes other than those listed in the FDA approval; or
    (b) Medical or scientific evidence demonstrates that the expected Benefits of the recommended or requested Health Care service or treatment is more likely than not to be more beneficial to the Covered Person than any available standard Health Care service or treatment and the adverse risks of the recommended or requested Health Care service or treatment would not be substantially increased over those of available standard Health Care services or treatments.

Within 45 calendar days after the date of receipt of the request for an External Review, the IRO shall provide written notice of its decision to uphold or reverse the Adverse Determination or the Final Adverse Determination to the Covered Person, the Covered Person's treating Health Care Professional, and the Company.

The IRO notice will include:

(a) A general description of the reason for the request for External Review;
(b) The date the IRO received the assignment from the health carrier to conduct the preliminary review of the External Review request;
(c) The date the External Review was conducted, if appropriate;
(d) The date of its decision;
(e) The principal reason or reasons for its decision;
(f) The rationale for its decision; and
(g) References to the evidence or documentation, including the practice guidelines, considered in reaching its decision.

If the Adverse Determination involves a denial of coverage based on a determination that the recommended or requested Health Care services is "experimental" or "investigational," the IRO shall also consider whether:

(i) A description of the indicators relevant to determining whether there is sufficient evidence to demonstrate that the recommended or requested Health Care service or treatment is more likely than not to be more beneficial to the Covered Person than any available standard Health Care services or treatments and the adverse risks of the recommended or requested Health Care service or treatment would not be substantially increased over those of available standard Health Care services or treatments; and

(ii) A description and analysis of any Medical or Scientific Evidence considered in reaching the opinion.

Upon receipt of a notice of a decision reversing the Adverse Determination or Final Adverse Determination, the Company will immediately approve the coverage that was the subject of the Adverse Determination or Final Adverse Determination.

The assignment by the Company of an approved IRO to conduct an External Review in accordance with this section shall be fair and impartial. the Company and the IRO shall comply with standards approved by the Commissioner to ensure fairness and impartiality in the assignment by health carriers of approved IRO to conduct External Reviews.

Expedited External Review – A Covered Person may make a request for an Expedited External Review at the time the Covered Person receives an Adverse Determination or a Final Adverse Determination.

The Covered Person may request an expedited External Review of an Adverse Determination if:

(a) The Covered Person has a medical condition where the timeframe for completion of an expedited review of an appeal set forth in the Company's internal grievance procedure or Utilization Review procedure would seriously jeopardize the life or health of the Covered Person or would jeopardize the Covered Person's ability to regain maximum function; or
(b) The Adverse Determination involves a denial of coverage based on a determination that the recommended or requested Health Care service or treatment is "experimental" or "investigational," and the Covered Person's treating physician certifies in writing that the recommended or requested Health Care service or treatment would be significantly less effective if not promptly initiated.

Note: A Covered Person may file a request for an expedited External Review at the same time the Covered Person files a request for an expedited review of an appeal under the Company's grievance or utilization review procedure if:

(a) The Covered Person has a medical condition where the timeframe for completion of an expedited review of an appeal set forth in the Company's internal grievance procedure or utilization review procedure would seriously jeopardize the life or health of the Covered Person or would jeopardize the Covered Person's ability to regain maximum function; or
(b) The Adverse Determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is "experimental" or "investigational," and the Covered Person's treating physician certifies in writing that the recommended or requested health care service or treatment would be significantly less effective if not promptly initiated.

The IRO will determine whether the Covered Person shall be required to complete the Company's expedited internal grievance procedure or Utilization Review procedure before it conducts the expedited External Review. Upon a determination that the Covered Person must first complete the expedited internal grievance review procedure or Utilization Review procedure, the IRO immediately shall notify the Covered Person and the Covered Person's treating Health Care Professional of this determination and that it will not proceed with the expedited External Review until the expedited internal grievance procedure or Utilization Review procedure is completed and the Adverse Determination or Final Adverse Determination is upheld.

The Covered Person may request an expedited External Review of a Final Adverse Determination if:

(a) The Covered Person has a medical condition where the timeframe for completion of a standard External Review would seriously jeopardize the life or health of the Covered Person, or would jeopardize the Covered Person's ability to regain maximum function; or
(b) The Final Adverse Determination concerns:

(i) An admission, availability of care, continued stay or Health Care service for which the Covered Person received Emergency Services, but has not been discharged from a Facility; or

(ii) A denial of coverage based on a determination that the recommended or requested Health Care service or treatment is experimental or investigational, and the Covered Person's treating physician certifies in writing that the recommended or requested Health Care service or treatment that is the subject of the request would be significantly less effective if not promptly initiated.

At the time the Covered Person makes a request for an expedited External Review, the Covered Person or the Covered Person's treating Health Care Professional shall submit additional information and supporting documentation that the IRO will consider when conducting the expedited External Review.

At the time the Company receives a request for an expedited External Review, the Company will immediately assign an IRO to the case.

At the time the Company assigns an IRO to conduct the expedited External Review, the Company shall immediately provide or transmit all documents and information considered in making the Adverse Determination or

Final Adverse Determination, as well as any additional information and supporting documentation, to the IRO, the Covered Person, and the Covered Person's treating Health Care Professional via electronically, facsimile or any other available expeditious method.

The IRO will, as expeditiously as the Covered Person's medical condition or circumstances require, but in no event more than 72 hours after the date of receipt of the request for an acceptable expedited External Review:

(a) Make a decision to uphold or reverse the Adverse Determination or Final Adverse Determination; and
(b) Notify the Covered Person, the Covered Person's treating Health Care Professional, and the Company of the decision.

If the notice from the IRO was not in writing, within 2 days after the date of providing that notice, the IRO shall:

(a) Provide a written or electronic media confirmation of the decision to the Covered Person and the Company; and
(b) Include the information required for a Standard External Review Notice.

In reaching a decision, the IRO is not bound by any decisions or conclusions reached during the health carrier's Utilization Review process or the Company's internal grievance process.

Upon receipt of notice of a decision reversing the Adverse Determination or Final Adverse Determination, the Company will immediately approve the coverage that was the subject of the Adverse Determination or Final Adverse Determination.

An expedited External Review may not be provided for adverse or Final Adverse Determinations involving a Retrospective Review.

Binding Nature of External Review Decision -

(a) An External Review decision is binding on the Company except to the extent the Company has other remedies available under applicable federal or state law.

(b) An External Review decision is binding on the Covered Person except to the extent the Covered Person has other remedies available under applicable federal or state law.

(c) A Covered Person may not file a subsequent request for External Review involving the same Adverse Determination or Final Adverse Determination for which the Covered Person has already received an External Review decision pursuant to this regulation.

Filing Fees –

(a) Except in the case of a request for an expedited External Review, at the time of filing a request for External Review, the Covered Person shall submit to the IRO a filing fee of $25 along with the information and documentation to be used by the IRO in conducting the External Review.

(b) Upon application by the Covered Person, the Commissioner may waive the filing fee upon a showing of undue financial hardship.

(c) The filing fee shall be refunded to the person who paid the fee if the External Review results in the reversal, in whole or in part, of the Company's Adverse Determination or Final Adverse Determination that was the subject of the External Review.

(d) the Company against which a request for a standard External Review or an expedited External Review is filed shall pay the cost of the IRO for conducting the External Review.

AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS
HOME OFFICE: ONE MOODY PLAZA
GALVESTON, TEXAS

GROUP HOSPITAL INSURANCE CERTIFICATE

THE GROUP POLICY PROVIDES COVERAGE FOR HOSPITAL EXPENSES DESCRIBED IN THE GROUP POLICY AND THIS CERTIFICATE. WHEN SELECTED, A PREFERRED PROVIDER COMPONENT IS INCLUDED WITH THIS COVERAGE.

AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS

A Stock Life Insurance Company
HOME OFFICE: ONE MOODY PLAZA
GALVESTON, TEXAS 77550

GROUP HOSPITAL INSURANCE CERTIFICATE

We pay benefits in accordance with all the terms and conditions of the Group Policy for Medical Service charges that are described in the section called "Medical Services" and incurred by a Covered Person as the result of the Medically Necessary treatment of:

INJURY that occurs after his/her Certificate Date; or

SICKNESS that begins after his/her Certificate Date.

This Certificate is not the contract of insurance, however it provides evidence of coverage under the Group Policy. **READ IT CAREFULLY.**

IMPORTANT NOTICE CONCERNING STATEMENTS IN YOUR ENROLLMENT APPLICATION - You should read Your Enrollment Application and all documents attached to this Certificate. **Omissions or misstatements in Your Enrollment Application or any attached documents may cause Us to deny an otherwise valid claim or rescind coverage.** Carefully check all documents. You must advise Our Underwriting Department in writing within 10 days of Your receipt of this Certificate if You determine that any information or medical history is incomplete, incorrect, or has changed since the date of Your Enrollment Application.

Your Enrollment Application and all attached documents are part of the Group Policy. We provide coverage described in the Group Policy on the basis that all of the answers to the questions and all the material information contained in the documents are correct and complete. No agent or employee, except an officer of the Company, has the authority to waive any of the requirements in the documents or waive any of the provisions of the Group Policy.

We do not provide coverage until we have approved Your Enrollment Application and Your Initial Premium has been paid. The Initial Premium pays for the Initial Term of coverage. The Initial Term of coverage begins at 12:01 A.M., local time, at Your residence on Your Certificate Date. Coverage is continued in accordance with all of the provisions of the Group Policy.

10 DAY RIGHT TO EXAMINE THIS CERTIFICATE – You may return this Certificate to Us for any reason within 10 days after You receive it. You may bring it in person or mail it to Us. At the time You return this Certificate, coverage under the Group Policy is void from the beginning. We will refund any premium paid.

PREMIUMS ARE SUBJECT TO CHANGE - Please refer to the section titled **PREMIUMS**.

THE GROUP POLICY – You may review the Group Policy during usual business hours at the Group Policyholder's office.

SECRETARY

PRESIDENT

THE GROUP POLICY PROVIDES COVERAGE FOR HOSPITAL EXPENSES DESCRIBED IN THE GROUP POLICY AND THIS CERTIFICATE. WHEN SELECTED, A PREFERRED PROVIDER COMPONENT IS INCLUDED WITH THIS COVERAGE.

CERTIFICATE SCHEDULE

REMARKS - SEE ANY ATTACHED FORMS

NOTICE –

BENEFIT OPTION – A
COVERAGE – INDIVIDUAL/ FAMILY
DEDUCTIBLE AMOUNT – ($750, $1,500, $2,000, $2,500, $5,000, $10,000, $15,000, $20,000, $25,000) PER COVERED PERSON PER CALENDAR YEAR
RATE OF PAYMENT – (100%, 80%, 50%)
STOP-LOSS AMOUNT - ($5,000, $10,000)
MAXIMUM POLICY BENEFIT FOR EACH INJURY OR SICKNESS PER COVERED PERSON -- $1,000,000 ($2,000,000)

REFER TO MEDICAL SERVICES FOR A DESCRIPTION OF EXPENSES COVERED BY THE POLICY.
REFER TO EXCEPTIONS FOR A DESCRIPTION OF EXPENSES THAT ARE NOT COVERED BY THE POLICY.

CERTIFICATE NUMBER:
CERTIFICATE DATE:

COVERED PERSONS:	**RELATIONSHIP**	**AGE**	**DATE OF BIRTH**

GROUP POLICY NUMBER:
GROUP POLICY DATE:
GROUP POLICYHOLDER:
STATE OF ISSUE:

CERTIFICATE SCHEDULE

REMARKS - SEE ANY ATTACHED FORMS

NOTICE –

BENEFIT OPTION – A
COVERAGE – INDIVIDUAL/ FAMILY
DEDUCTIBLE AMOUNT – ($750, $1,500, $2,000, $2,500, $5,000, $10,000, $15,000, $20,000, $25,000) PER COVERED PERSON PER CALENDAR YEAR
RATE OF PAYMENT –
IN-NETWORK - (100%, 80%, 50%)
OUT-OF-NETWORK - (80% OF THE FIRST $5,000, 100% THEREAFTER)

(60% UP TO THE STOP LOSS AMOUNT, 100% THEREAFTER)

(30% UP TO THE STOP LOSS AMOUNT, 100% THEREAFTER)

STOP-LOSS AMOUNT - ($5,000, $10,000)
MAXIMUM POLICY BENEFIT FOR EACH INJURY OR SICKNESS PER COVERED PERSON -- $1,000,000 ($2,000,000)

REFER TO MEDICAL SERVICES FOR A DESCRIPTION OF EXPENSES COVERED BY THE POLICY.
REFER TO EXCEPTIONS FOR A DESCRIPTION OF EXPENSES THAT ARE NOT COVERED BY THE POLICY.

CERTIFICATE NUMBER:
CERTIFICATE DATE:

COVERED PERSONS:	**RELATIONSHIP**	**AGE**	**DATE OF BIRTH**

GROUP POLICY NUMBER:
GROUP POLICY DATE:
GROUP POLICYHOLDER:
STATE OF ISSUE:

CERTIFICATE SCHEDULE

REMARKS - SEE ANY ATTACHED FORMS

NOTICE –

BENEFIT OPTION – B

RATE OF PAYMENT – (100%)
DEDUCTIBLE AMOUNT – ($3,000, $4,000, $5,000, $10,000)
UNPAID MEDICAL SERVICE
CHARGE MAXIMUM - ($3,000, $4,000, $5,000, $10,000) INCLUDES DEDUCTIBLE

RATE OF PAYMENT – (80%)
DEDUCTIBLE AMOUNT – ($3,000, $4,000, $5,000, $10,000)
UNPAID MEDICAL SERVICE
CHARGE MAXIMUM - ($7,000, $8,000, $9,000, $14,000) INCLUDES DEDUCTIBLE

RATE OF PAYMENT – (50%)
DEDUCTIBLE AMOUNT – ($3,000, $4,000, $5,000, $10,000)
UNPAID MEDICAL SERVICE
CHARGE MAXIMUM - ($8,000, $9,000, $10,000, $15, 000) INCLUDES DEDUCTIBLE

MAXIMUM POLICY BENEFIT FOR EACH
INJURY OR SICKNESS PER COVERED PERSON -- $1,000,000 ($2,000,000)

REFER TO MEDICAL SERVICES FOR A DESCRIPTION OF EXPENSES COVERED BY THE POLICY.
REFER TO EXCEPTIONS FOR A DESCRIPTION OF EXPENSES THAT ARE NOT COVERED BY THE POLICY.

CERTIFICATE NUMBER:
CERTIFICATE DATE:

COVERED PERSONS:	**RELATIONSHIP**	**AGE**	**DATE OF BIRTH**

GROUP POLICY NUMBER:
GROUP POLICY DATE:
GROUP POLICYHOLDER:
STATE OF ISSUE:

CERTIFICATE SCHEDULE

REMARKS - SEE ANY ATTACHED FORMS

NOTICE –

BENEFIT OPTION – B

RATE OF PAYMENT –
IN-NETWORK - (100%)
OUT-OF-NETWORK - (80%)
DEDUCTIBLE AMOUNT – ($3,000, $4,000, $5,000, $10,000)
UNPAID MEDICAL SERVICE
CHARGE MAXIMUM - ($3,000, $4,000, $5,000, $10,000) INCLUDES DEDUCTIBLE

RATE OF PAYMENT –
IN-NETWORK – (80%)
OUT-OF-NETWORK - (60%)
DEDUCTIBLE AMOUNT – ($3,000, $4,000, $5,000, $10,000)
UNPAID MEDICAL SERVICE
CHARGE MAXIMUM - ($7,000, $8,000, $9,000, $14,000) INCLUDES DEDUCTIBLE

RATE OF PAYMENT –
IN-NETWORK - (50%)
OUT-OF-NETWORK - (30%)
DEDUCTIBLE AMOUNT – ($3,000, $4,000, $5,000, $10,000)
UNPAID MEDICAL SERVICE
CHARGE MAXIMUM - ($8,000, $9,000, $10,000, $15, 000) INCLUDES DEDUCTIBLE

MAXIMUM POLICY BENEFIT FOR EACH
INJURY OR SICKNESS PER COVERED PERSON -- $1,000,000 ($2,000,000)

REFER TO MEDICAL SERVICES FOR A DESCRIPTION OF EXPENSES COVERED BY THE POLICY.
REFER TO EXCEPTIONS FOR A DESCRIPTION OF EXPENSES THAT ARE NOT COVERED BY THE POLICY.

CERTIFICATE NUMBER:
CERTIFICATE DATE:
COVERED PERSONS: RELATIONSHIP AGE DATE OF BIRTH

GROUP POLICY NUMBER:
GROUP POLICY DATE:
GROUP POLICYHOLDER:
STATE OF ISSUE:

CERTIFICATE SCHEDULE

REMARKS - SEE ANY ATTACHED FORMS

THE PLAN DEDUCTIBLE AND UNPAID MEDICAL SERVICES MAXIMUM WILL CHANGE IN ACCORDANCE WITH FEDERAL REQUIREMENTS.

NOTICE –

COVERAGE – (INDIVIDUAL/ FAMILY**)**
BENEFIT OPTION – NOT APPLICABLE
RATE OF PAYMENT – (100%)
DEDUCTIBLE AMOUNT –
INDIVIDUAL - ($1,500, $2,000, $2,500, $5,000)
FAMILY - ($3,000, $4,000, $5,000, $10,000)
UNPAID MEDICAL SERVICE CHARGE MAXIMUM - **INDIVIDUAL** - ($1,500, $2,000, $2,500, $5,000) INCLUDES DEDUCTIBLE
FAMILY - ($3,000, $4,000, $5,000, $10,000) INCLUDES DEDUCTIBLE

RATE OF PAYMENT – (80%)
DEDUCTIBLE AMOUNT –
INDIVIDUAL - ($1,500, $2,000, $2,500)
FAMILY - ($3,000, $4,000, $5,000)
UNPAID MEDICAL SERVICE CHARGE MAXIMUM - **INDIVIDUAL** - ($3,500, $4,000, $4,500) INCLUDES DEDUCTIBLE
FAMILY - ($7,000, $8,000, $9,000) INCLUDES DEDUCTIBLE

RATE OF PAYMENT – (50%)
DEDUCTIBLE AMOUNT –
INDIVIDUAL - ($1,500, $2,000, $2,500)
FAMILY - ($3,000, $4,000, $5,000)
UNPAID MEDICAL SERVICE CHARGE MAXIMUM - **INDIVIDUAL** - ($4,000, $4,500, $5,000) INCLUDES DEDUCTIBLE
FAMILY - ($8,000, $9,000, $10,000) INCLUDES DEDUCTIBLE

MAXIMUM POLICY BENEFIT FOR EACH INJURY OR SICKNESS PER COVERED PERSON -- $1,000,000 ($2,000,000)

REFER TO MEDICAL SERVICES FOR A DESCRIPTION OF EXPENSES COVERED BY THE POLICY.
REFER TO EXCEPTIONS FOR A DESCRIPTION OF EXPENSES THAT ARE NOT COVERED BY THE POLICY.

CERTIFICATE NUMBER:
CERTIFICATE DATE:

COVERED PERSONS:	**RELATIONSHIP**	**AGE**	**DATE OF BIRTH**

GROUP POLICY NUMBER:
GROUP POLICY DATE:
GROUP POLICYHOLDER:
STATE OF ISSUE:

CERTIFICATE SCHEDULE

REMARKS - SEE ANY ATTACHED FORMS
THE PLAN DEDUCTIBLE AND UNPAID MEDICAL SERVICES MAXIMUM WILL CHANGE IN ACCORDANCE WITH FEDERAL REQUIREMENTS.

NOTICE –OUT-OF-NETWORK PENALTY – COVERAGE UNDER THE GROUP POLICY INCLUDES A PPO COMPONENT. THE CERTIFICATEHOLDER IS ENCOURAGED TO USE AN IN-NETWORK PROVIDER TO RECEIVE THE MAXIMUM AMOUNT PAYABLE FOR ELIGIBLE MEDICAL SERVICE CHARGES. USE OF AN OUT-OFNETWORK PROVIDER RESULTS IN A 20% REDUCTION OF ANY OTHERWISE ELIGIBLE MEDICAL SERVICE CHARGE THAT WE DO NOT PAY DUE TO A COVERED PERSON'S VOLUNTARY USE OF AN OUT-OF-NETWORK PROVIDER.

COVERAGE – (INDIVIDUAL/ FAMILY**)**
BENEFIT OPTION – NOT APPLICABLE
RATE OF PAYMENT – (100%)
DEDUCTIBLE AMOUNT –
INDIVIDUAL - ($1,500, $2,000, $2,500, $5,000)
FAMILY - ($3,000, $4,000, $5,000, $10,000)
UNPAID MEDICAL SERVICE
CHARGE MAXIMUM - INDIVIDUAL - ($1,500, $2,000, $2,500, $5,000) INCLUDES DEDUCTIBLE
FAMILY - ($3,000, $4,000, $5,000, $10,000) INCLUDES DEDUCTIBLE

RATE OF PAYMENT – (80%)
DEDUCTIBLE AMOUNT –
INDIVIDUAL - ($1,500, $2,000, $2,500)
FAMILY - ($3,000, $4,000, $5,000)
UNPAID MEDICAL SERVICE
CHARGE MAXIMUM - INDIVIDUAL - ($3,500, $4,000, $4,500) INCLUDES DEDUCTIBLE
FAMILY - ($7,000, $8,000, $9,000) INCLUDES DEDUCTIBLE

RATE OF PAYMENT – (50%)
DEDUCTIBLE AMOUNT –
INDIVIDUAL - ($1,500, $2,000, $2,500)
FAMILY - ($3,000, $4,000, $5,000)
UNPAID MEDICAL SERVICE
CHARGE MAXIMUM - INDIVIDUAL - ($4,000, $4,500, $5,000) INCLUDES DEDUCTIBLE
FAMILY - ($8,000, $9,000, $10,000) INCLUDES DEDUCTIBLE

MAXIMUM POLICY BENEFIT FOR EACH
INJURY OR SICKNESS PER COVERED PERSON -- $1,000,000 ($2,000,000)

REFER TO MEDICAL SERVICES FOR A DESCRIPTION OF EXPENSES COVERED BY THE POLICY.
REFER TO EXCEPTIONS FOR A DESCRIPTION OF EXPENSES THAT ARE NOT COVERED BY THE POLICY.

CERTIFICATE NUMBER:
CERTIFICATE DATE:
COVERED PERSONS: RELATIONSHIP AGE DATE OF BIRTH

GROUP POLICY NUMBER:
GROUP POLICY DATE:
GROUP POLICYHOLDER:
STATE OF ISSUE:

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PREMIUMS

Premiums are due on the first day of each term that follows the Initial Term. This is called the Premium Due Date. The required premium will depend on Your premium class. We determine the premium class on each Premium Due Date. We will NOT CHANGE Your premium prior to the first anniversary of Your Certificate Date, unless:

1. Coverage changes; or
2. Residence changes.

After the first anniversary of Your coverage, We will change premiums:

1. Annually, based on attained age;
2. When You move to a different rating zone; or
3. Anytime, and from time to time, that We decide to change rates for persons in Your or a Covered Person's class.

Changes will apply to premiums due on or after the effective date of the change. The new rates will apply on a class basis as determined by Us. We will give You 30 days notice before any premium change.

WAIVER OF PREMIUM - If You die, We will waive premiums for remaining Covered Persons for 12 months beginning with the next Premium Due Date following Our receipt of due proof of Your death. During this premium waiver period no increases in benefits or addition of Covered Persons, except newborns, will be considered. All provisions for Loss of Eligibility for Covered Persons will remain applicable during this premium waiver period.
At the end of the 12 months during which premiums were waived, coverage may be continued for Covered Persons by resuming payment of the required premium.

DEFINITIONS

AMBULANCE means a motor vehicle, helicopter, or fixed wing aircraft specially equipped to transport Sick and Injured people. A common carrier is not an Ambulance.

CALENDAR YEAR means the twelve-month period that begins January 1 and ends December 31, each year.

CERTIFICATE means the written description of coverage provided to You as evidence of coverage under the Group Policy.

CERTIFICATE DATE means the date, shown in the Certificate Schedule, when coverage begins for the Covered Persons originally covered under the Group Policy. We use the Certificate Date to determine the anniversary dates of coverage under the Group Policy. It also refers, separately, to the date We add a Covered Person to the Group Policy or when any change in coverage occurs.

CERTIFICATEHOLDER means the Applicant named in the Enrollment Application or any successor thereof named to assume ownership privileges under this Policy. Such person, regardless of title, has exclusive ownership privileges under this Policy. These privileges include, but are not limited to, his/her right to change coverage under this Policy for themselves or any Covered Person.

CLOSE RELATIVE means You or anyone related to You by blood, marriage, or adoption; or a court appointed representative.

COMPLICATIONS OF PREGNANCY means:

1. conditions, requiring Hospital confinement (when the pregnancy is not terminated), whose diagnosis are distinct from pregnancy, but are adversely affected by pregnancy or are caused by pregnancy, such as (1) acute nephritis; (2) nephrosis; (3) cardiac decompensation;(4) HELLP syndrome; (5) uterine rupture; (6) amniotic fluid embolism; (7) chorioamnionitis; (8) fatty liver in pregnancy; (9) septic abortion; (10) placenta accreta; (11) gestational hypertension; (12) puerperal sepsis; (13) peripartum cardiomyopathy; (14) cholestasis in pregnancy; (15) thrombocytopenia in pregnancy; (16) placenta previa; (17) placental abruption; (18) acute cholecystitis and pancreatitis in pregnancy; (19) postpartum hemmorrhage; (20) septic pelvic thromboplebitis; (21) retained placenta; (22) venous air embolus associated with pregnancy; (23) miscarriage; or (24) an emergency c-section required because of (a) fetal or maternal distress during labor, or (b) severe pre-eclampsia, or (c) arrest of descent or dilitation, or (d) obstruction of the birth canal by fibroids or ovarian tumors, or (e) necessary because of the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that, in the absence of immediate medical attention, will result in placing the life of the mother or fetus in jeopardy. A c-section delivery is not considered to be an emergency c-section if it is merely for the convenience of the patient and/or doctor or solely due to a previous c-section; and

2. Treatment, diagnosis or care for conditions, including the following, when the condition was caused by, necessary because of, or aggravated by the pregnancy: (1) hyperthyroidism, (2) hepatitis B 0r C, (3) HIV (4) Human papilloma virus, (5) abnormal PAP, (6) syphilis, (7) chlamydia, (8) herpes, (9) urinary tract infections, (10) thromboembolism, (11) appendicitis, (12) hypothyroidism, (13) pulmonary embolism, (14) sickle cell disease, (15) tuberculosis, (16) migraine headaches, (17) depression, (18) acute myocarditis, (19) asthma, (20) maternal cytomegalovirus, (21) urolithiasis, (22) DVT prophylaxis, (23) ovarian dermoid tumors, (24) biliary atresia and/or cirrhosis, (25) first trimester adnexal mass, (25) hyditidiform mole or (26) ectopic pregnancy.

COVERED PERSON means each person named as a Covered Person on the Certificate Schedule whose coverage under the Group Policy has not terminated.

DOCTOR means a person, other than You or a Close Relative, who is duly licensed to provide the type of medical treatment for which benefits are provided under the Group Policy, and acting within the scope of that license.

EMERGENCY means a medical condition of recent onset and sufficient severity to cause a prudent person to believe that without immediate medical attention the condition may result in:

1. Placing the patient's health in serious jeopardy;
2. Serious impairment to bodily functions;
3. Serious dysfunction of any bodily organ or part;
4. Serious disfigurement; or
5. In the case of a pregnant woman, serious jeopardy to the health of the fetus.

EXPERIMENTAL OR INVESTIGATIONAL MEDICINE means any of the following (generally, individually or collectively, called Regimen) that, when used to treat a Covered Person's specific Injury or Sickness, are experimental, investigational or oriented toward research:

1. Equipment;
2. Drugs or dosages;
3. Devices, services, supplies, tests or medical treatment or procedures; or
4. All related treatment and procedures.

We consider a Regimen as **EXPERIMENTAL OR INVESTIGATIONAL MEDICINE** if:

1. The U.S. Food and Drug Administration (FDA) has not given final approval to the Regimen for the lawful marketing for the treatment of the specific Injury or Sickness; or
2. The American Medical Association (AMA) has not approved or endorsed the Regimen for the treatment of the specific Injury or Sickness; or
3. The National Institutes of Health (NIH) or its affiliated institutes have not approved or endorsed the Regimen for the treatment of the specific Injury or Sickness; or
4. The Regimen is:

    a) Currently used or will be used or studied in proposed or ongoing clinical research or clinical trials as evidenced by the Informed Consent or investigational protocol; or
    b) Part of a proposed or ongoing phase I, II or III clinical trial; or
    c) Subject of proposed or ongoing research or studies to determine its dosage, safety, toxicity, efficacy, or its efficacy as compared to other means of treatment or diagnosis; or

5. The opinion of medical or scientific experts indicates that further studies, research or clinical trials are necessary to determine the Regimen's dosage, safety, toxicity, efficacy or its efficacy as compared to other means of treatment or diagnosis. The opinion of medical or scientific experts is as reflected in:

    a) Published reports or articles in medical or scientific literature; or
    b) Written protocol(s) used by the treating facility or other facilities studying the same or substantially similar Drugs, devices, services, supplies, tests, treatments, or procedures; or
    c) The Informed Consent used by the treating facility or other facilities studying the same or substantially similar Drugs, devices, services, supplies, tests, treatments, or procedures.

We will not exclude a drug for the treatment of cancer because the FDA has not approved the drug for the treatment of the specific type of cancer for which a Doctor has prescribed the drug. However, standard reference compendia or medical literature must recognize the drug for treatment of that specific type of cancer. We will not cover a drug:

1. That the FDA has not approved; or
2. The FDA has contraindicated its use.

HOME HEALTH CARE PLAN means that a licensed Home Health Care Agency provides care and treatment for an Injury or Sickness at a Covered Person's residence. A Doctor must set up and approve a plan in writing.

HOSPICE means an alternative way of caring for terminally ill individuals provided by an entity licensed to provide hospice care for terminally ill individuals and his/her Immediate Families.

HOSPITAL means a facility that:
1. Is licensed as a Hospital in the jurisdiction where it operates; and
2. Provides medical and surgical services for the treatment of Injury or Sickness under the supervision of a Doctor.

The term "Hospital" does not include:

1. A convalescent, nursing, rest or rehabilitative facility; a home for the aged; a special ward, floor or other accommodation for convalescent, skilled nursing, rehabilitation, ambulatory or extended care purposes, including the separate section of a building that houses an acute care facility; hotel units, residential annexes, nurse administered units in or associated with a Hospital; or a psychiatric/substance abuse facility.

2. Any military or veteran's Hospital, soldier's home or any Hospital contracted for or operated by the Federal Government or any agencies thereof for the treatment of members or former members of the Armed Forces, unless the Covered Person is legally required to pay for services in the absence of coverage under the Group Policy.

HOSPITAL CONFINED means that a Covered Person is admitted to a Hospital as an overnight resident bed patient. "Hospital Confined" does not include a Covered Person's treatment in a Same Day Surgery facility, Emergency room, or an observation room.

INJURY (Injured) means accidental bodily injury sustained by the Covered Person, which is the direct cause of loss, independent of disease, bodily infirmity, or any other cause which occurs while coverage under the Group Policy is in force.

INTENSIVE CARE UNIT, CORONARY CARE UNIT OR NEONATAL INTENSIVE CARE UNIT means that part of a Hospital specifically designed as an intensive care unit that is permanently equipped and staffed to provide more extensive care for critically ill or Injured patients than is available in other Hospital rooms or wards. Services provided include close observation by trained and qualified personnel whose duties are primarily confined to the part of the Hospital for which an additional charge is made.

LIMITING AGE for Your children is attained age 26. This is Your coverage anniversary next following the child's 26th birthday.

MEDICALLY NECESSARY means a service or supply necessary and appropriate for the diagnosis or treatment of an Injury or Sickness based upon current generally accepted medical practices. The fact that a Doctor may prescribe, order, recommend, or approve a service or supply does not, of itself, make the service or supply Medically Necessary. A service or supply is not Medically Necessary if:

1. It is provided only as a convenience to the Covered Person or provider;
2. It is not appropriate treatment for the Covered Person's diagnosis or symptoms;
3. It exceeds (in scope, duration, or intensity) that level of care that is needed to provide safe, adequate, and appropriate diagnosis or treatment; or
4. It is Experimental or Investigational Medicine.

MEDICARE means a United States government program set up to provide health care benefits. Medicare includes:

1. The program under Title XVIII of Social Security with any later changes; or
2. Similar programs meant to pay for health care.

MEDICINES OR DRUGS means any medication or medicinal substance that the U.S. Food and Drug Administration has approved for use. The Medicines or Drugs must be used in the Hospital.

MENTAL DISORDER means a disease or disorder, regardless of its cause, that affects the mind or behavior. Categories of mental disorders include mood disorders, anxiety disorders, psychotic disorders, eating disorders, developmental disorders, personality disorders, and other generally accepted disorders of a similar type.

NURSE means any of these:

1. Licensed Registered Nurse (R.N.);
2. Licensed Practical Nurse (L.P.N.);
3. Licensed Vocational Nurse (L.V.N.); or
4. Nurse Practitioner.

"Nurse" does not include a Covered Person or any Close Relative.

ORGAN TRANSPLANT means the placement of tissue or an organ from a live or cadaver donor in a Covered Person. This includes tissue, organ, or cells harvested and returned to the same person, where such tissue or organ is somewhat independent from all other parts of the human body and performs a special or unique function. The source of the tissue, organ, or cells may be from another person. An Organ Transplant does not include the placement of a mechanical or man-made device or substance when the device or substance:

1. Is intended to serve as a substitute for the tissue or organ; or
2. Aids in the performance of the tissue or organ.

An Organ Transplant does not include the grafting of solid tissue or organ such as bone or skin.

PREEXISTING CONDITION means a disease or physical condition of a Covered Person, not otherwise excluded by name or specific description on the date of the Person's loss, which existed prior to the Covered Person's effective date under the Group Policy. Any exclusion or limitation applies only to a disease or physical condition for which medical advice or treatment was received by the Covered Person during the 12 months prior to the effective date of coverage under the Group Policy. In no event will the exclusion or limitation apply to loss incurred after the earlier of:

1. The end of a continuous period of 12 months commencing on or after the effective date of the Covered Person's coverage during all of which the Person received no advice or treatment in connection with such disease or physical condition; or
2. The end of the 2-year period commencing on the effective date of the Covered Person's effective date of coverage under the Group Policy.

REASONABLE AND CUSTOMARY CHARGES means the dollar amount charged that is the lesser of:

1. The actual dollar amount charged;
2. The dollar amount usually charged for the service by the provider who furnishes it; or
3. The prevailing dollar amount charge made for a service in a geographical area made by a facility or person.

SAME DAY SURGERY FACILITY means a licensed medical facility or a part of a Hospital:

1. With an organized staff of Doctors;
2. That is permanently equipped and operated primarily for the purpose of performing surgical procedures;
3. That does not provide accommodations for overnight stays; and
4. That provides continuous Doctor services and nursing services whenever a patient is in the facility.

The term "Same Day Surgery Facility" does not include a:

1. Hospital Emergency room;
2. Trauma center; or
3. Doctor's office or Clinic.

SICKNESS means a Covered Person's illness, disease, or condition that begins after the Certificate Date and while the Covered Person has coverage under the Group Policy. Sickness also includes an illness, disease or condition that begins before the Certificate Date if it is shown on the Enrollment Application and We have not excluded it from coverage by name or specific description. Sickness includes any complications or recurrences that relate to such Sickness while the Group Policy's coverage is in effect for the Covered Person.

US, WE, OUR or THE COMPANY means American National Life Insurance Company of Texas (ANTEX).

YOU or YOUR means the Certificateholder.

BENEFITS

WHAT WE PAY – Benefits are payable under the Group Policy in accordance with Benefit Option A or Benefit Option B, each described below. Each Certificateholder's selected Benefit Option is shown in Your Certificate Schedule. The Benefit Option in effect on January 1st of each year will remain in effect for the remainder of the same Calendar Year. Benefits will not be paid under more than one benefit option during a Calendar Year. All benefits payable under the Group Policy are subject to the Group Policy's Maximum Policy Benefit for each Injury or Sickness per Covered Person. A Covered Person's selected Deductible Amount, Rate of Payment, and Stop Loss Amount are each shown in his/her Certificate Schedule.

BENEFIT OPTION A - Benefits are payable under the Group Policy after a Covered Person incurs charges during a Calendar Year for Medical Services in excess of his/her Deductible Amount. Benefits will be paid at the Rate of Payment. If Your selected Rate of Payment is less than 100%, once charges for Medical Services exceed the Stop-Loss Amount shown in the Certificate Schedule during a Calendar Year, the Rate of Payment for the remainder of the Calendar Year is 100%.

BENEFIT OPTION B - Benefits are payable under the Group Policy after combined charges for Medical Services incurred by one or more Covered Persons during a Calendar Year exceed the Deductible Amount. Benefits will be paid at the Rate of Payment. If Your selected Rate of Payment is less than 100%, once combined unpaid charges for Medical Services incurred by one or more Covered Persons during a Calendar Year exceed the Unpaid Medical Service Charge Maximum shown in Your Certificate Schedule, the Rate of Payment for the remainder of the Calendar Year is 100%. In the event coverage under this Benefit Option B is provided for only one Covered Person, the Deductible Amount shown in Your Certificate Schedule will be reduced by 50%.

UNPAID MEDICAL SERVICES MAXIMUM – This is the maximum amount that You pay each Calendar Year comprised of charges for Medical Services applied to the Deductible Amount and Rate of Payment for Medical Services before We pay 100% of Medical Services charges. There is an Individual or a Family Unpaid Medical Services Maximum depending on whether family coverage is provided. Once Covered Persons have met the Family Unpaid Medical Services Maximum, individually or collectively, We will pay 100% of charges for Medical Services for all Covered Persons for the remainder of the Calendar Year. The Policy Schedule shows Unpaid Medical Services Maximum. **We <u>do not</u> apply the following toward the Unpaid Medical Services Maximum: any non-Medical Service charge, or ineligible expense.**

POLICY MAXIMUM FOR EACH INJURY OR SICKNESS is shown in each Certificateholder's Certificate Schedule. This Maximum applies to each Covered Person.

THE FOLLOWING PROVISIONS DO <u>NOT</u> APPLY IF BENEFIT OPTION B IS IN EFFECT.

FAMILY DEDUCTIBLE MAXIMUM – Once three family members have met their respective Deductible Amounts in a Calendar Year, no further Deductible Amount will be required for the remainder of the Calendar Year.

COMMON ACCIDENT DEDUCTIBLE – If two or more Covered Persons incur Medical Service charges from Injuries sustained in a single accident, We will apply the lesser of:

1. The Deductible Amount;
2. The remainder of each Covered Person's respective Deductible Amount; or
3. The remainder of the Family Deductible Maximum.

VANISHING DEDUCTIBLE AMOUNT – This provision does not apply to a Deductible Amount in excess of $15,000. If coverage under the Group Policy is in effect for a complete Calendar Year and We do not pay any benefits on behalf of any Covered Person, We will reduce the Cash Deductible Amount for the following Calendar Year by 25%. However, We will give no further reductions after the Cash Deductible Amount is reduced to zero. If We pay benefits on behalf of any Covered Person during a Calendar Year, the Cash Deductible Amount for all Covered Persons for the next Calendar Year is the amount shown on the Certificate Schedule. We will extend this provision to any Covered Person added during a Calendar Year during which the Cash Deductible Amount has been reduced.

MEDICAL SERVICES

WE PAY BENEFITS FOR REASONABLE AND CUSTOMARY CHARGES INCURRED FOR THE FOLLOWING MEDICAL SERVICES AT THE APPLICABLE RATE OF PAYMENT. Benefits payable for Medical Services are subject to all terms, limits, and conditions of the Group Policy.

An expense is "incurred" on the date a provider renders the service or furnishes the supplies.

The following are Medical Services under the Group Policy :

Professional Ambulance Service (air or ground) – Reasonable and Customary Charges for transportation to the nearest Hospital qualified to provide for the Covered Person's Medically Necessary Emergency treatment.

Hospital Stay - The Hospital charge for each day a Covered Person is Hospital Confined. Such charge will include those for:

1. Semi-private room confinement, excluding any separate charges such as room, nursing services, maintenance, utilities, and similar items;
2. Intensive Care Unit, Burn Unit, Coronary Care Unit, and Neonatal Intensive Care Unit confinement, up to three times the Hospital's average semi-private room rate; and
3. Medically Necessary miscellaneous services and supplies used for the treatment of the Hospital Confined Covered Person.

Services **DO NOT** include: charges for take-home medicines or drugs, personal or convenience items, or items that are not intended primarily for use while Hospital Confined.

Doctor Visits - Reasonable and Customary Charges for the Covered Person's Doctors' (other than the surgeon) visits when Hospital Confined. For purposes of this provision, a Doctor's consultation is a visit.

Surgery - Reasonable and Customary Charges made by an operating surgeon. If two or more surgeries are performed through the same incision, We will pay the one providing the greatest benefit under the Group Policy. We will also pay [50%] of the benefits otherwise payable for the other surgeries performed through separate incisions during the same operative session. Charges must be incurred while a Covered Person is Hospital Confined or in a Same Day Surgery Facility.

Same Day Surgery Facility - Reasonable and Customary Charges for services provided for a Covered Person by a Same Day Surgery Facility on the day surgery is performed.

If a Covered Person is retained in the Same Day Surgery Facility for more than 18 hours, charges for use of such facility will be limited to the average semi-private room rate consistent with Reasonable and Customary Charges for Hospitals in the area where the Same Day Surgery Facility is located.

Assistant Surgeon - Actual charges for services provided during a surgical procedure by an Assistant Surgeon, up to 25% of the Reasonable and Customary Charge of the primary surgeon. Charges must be incurred while a Covered Person is Hospital Confined or in a Same Day Surgery Facility.

Second Surgical Opinion - Reasonable and Customary Charges for a Doctor providing a second surgical opinion regarding the recommendation for surgery. If the initial and second surgical opinions conflict, We will pay benefits for a third surgical opinion. The Deductible Amount does not apply to a second or third opinion.

Anesthesia Administration - Reasonable and Customary Charges for the administration of anesthesia by an anesthesiologist to a Covered Person undergoing surgery while Hospital Confined or in a Same Day Surgery Facility. The anesthesiologist must be at the operation solely to provide the anesthesia service.

We will reduce benefits otherwise payable had an anesthesiologist administered anesthesia by [50%] if a nurse anesthetist, operating Doctor, or assistant Surgeon administers the anesthesia, including any incidental fluids, as part of a covered surgical procedure. When both an anesthesiologist and a nurse anesthetist bill for the same operative session, benefits will be limited to the Reasonable and Customary charges otherwise payable had the anesthesiologist been the sole provider of such services.

Coverage includes charges incurred for those for services performed in connection with dental procedures in a Hospital or Ambulatory Surgical Center when the Doctor treating the Covered Person certifies that, because of the patient's age or condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the procedures and the Covered Person is: (1) a child under 7 years of age who is determined by two dentists licensed in Arkansas to require, without delay, necessary dental treatment in a Hospital or Ambulatory Surgical Center for a significantly complex dental condition; (2) a person with a diagnosed serious mental of physical condition; or (3) a person with a significant behavioral problem as determined by the Covered Person's Doctor. This benefit does not apply to services performed in connection with temporomandibular joint disorders.

Breast Reconstruction - Reasonable and Customary Charges for the following services and supplies incident to mastectomy:

1. Reconstruction of the affected breast;
2. Reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and physical complications of all stages of mastectomy, including lymphedemas.

Benefits under this coverage will be subject to all the terms and conditions of the Group Policy, except any Exception relating to cosmetic surgery.

Pathology - Reasonable and Customary Charges for pathology services while the Covered Person is Hospital Confined or in a Same Day Surgery Facility. Professional services relating to automated pathology tests are <u>not</u> covered.

Radiology - Reasonable and Customary Charges for radiology services provided for a Covered Person while Hospital Confined or in a Same Day Surgery Facility.

Chemotherapy – Reasonable and Customary Charges for chemotherapy.

Physiotherapy - Reasonable and Customary Charges for physical, speech, occupational, or inhalation therapy. Such therapy must be provided by a Hospital based therapy facility and must result from a Covered Person's treatment in a Hospital or Same Day Surgery Facility.

Radiation Therapy – Reasonable and Customary Charges for radiation therapy.

Home Health Care - Reasonable and Customary Charges for Home Health Care, up to [$7,500] per Calendar Year when a Covered Person receives Home Health Care. The Home Health Care must:

1. Begin within 7 days of a prior Hospital Stay of at least 3 days;
2. Be provided in lieu of a Hospital Stay;
3. Be for services related to the treatment of the same Sickness or Injury for which the Covered Person was Hospital Confined; and
4. Be administered under a Home Health Care Plan.

Hospice Care Benefit - Reasonable and Customary Charges for Hospice Care provided by a licensed Hospice agency. We will not pay benefits under this provision and under another benefit provision of the Group Policy. We only pay benefits for Hospice Care when the Covered Person's Doctor certifies that the Covered Person's life expectancy is less than six months.

Mammogram - Reasonable and Customary Charges in excess of a Covered Person's payment of [$25] for one mammogram per Calendar Year. We pay the benefit whether or not the Covered Person is Hospital Confined. We do not apply such payment to the Deductible Amount or the Rate of Payment.

Foreign Emergency Treatment - We will pay for benefits for Medical Services resulting from charges for Emergency treatment that a Covered Person receives in a foreign country. Benefits payable will be the lesser of: (1) the actual charges for the services; or (2) the benefit for Medical Services that We would have paid if the Covered Person had received the Emergency treatment in the location where the Covered Person resides.

Complications of Pregnancy - If a Covered Person has Complications of Pregnancy while covered under the Group Policy, Medical Services incurred for treatment of such Complications of Pregnancy will be considered for payment as if they had resulted from Sickness. If an expense does not result solely from the treatment of the Complications of Pregnancy, then it will be deemed due to normal pregnancy and not covered under the Group Policy.

Organ Transplant Donor Charges - We will pay donor benefits for covered Organ Transplants:

1. Up to [$15,000] in Medical Services; if
2. You or a Covered Person are legally responsible for the charges.

ARKANSAS RESIDENT BENEFITS – The following benefits apply only when described services are provided to a Covered Person who is an Arkansas resident. Except as otherwise stated, they are subject to all the terms and conditions of the Group Policy.

Newborn Infants – When the Certificate evidences coverage for persons in addition to You, and You have given Us notice of a newborn as required by Automatic Coverage of Newborn and Adopted Children, coverage will include the Reasonable and Customary Charges incurred for the Medically Necessary care and treatment of a newborn child, while the child is Hospital Confined, as follows: (a) coverage for Sickness or Injury, congenital defects, and premature birth; (b) coverage for tests for hypthyroidism, phenylketonuria, galactosemia, sickle-cell amenia, and all other disorders of metabolism for which screening is performed by or for the State of Arkansas, as well as any testing of newborn infants hereafter mandated by law; and (c) a minimum of 48 hours up to 5 full days of routine nursery care and pediatric charges for a well newborn in a Hospital nursery or until the mother is discharged from the Hospital following the birth of the child, whichever is the lesser period of time.

Speech and Hearing - Reasonable and Customary Charges incurred for necessary care and treatment of loss or impairment of speech or hearing while Hospital Confined. Coverage does not include hearing instruments or devices.

Colorectal Screening - Reasonable and Customary Charges for colorectal cancer examinations and laboratory tests, while Hospital Confined or in an Ambulatory Surgical Center, for: (1) Covered Persons who are 50 years of age or older; (2) Covered Persons who are less than 50 years of age and at a high risk for colorectal cancer; (3) Covered Persons experiencing the following symptoms: bleeding from the rectum or blood in the stool; a change in bowel habits, such as diarrhea, constipation, or narrowing of the stool, that lasts more than 5 days.

The colorectal screening will involve an examination of the entire colon, including the following exams or laboratory tests, or both:

1. An annual fecal immunochemical test in conjunction with a flexible sigmoidoscopy every 5 years;
2. A double-contrast barium enema every 5 years; or
3. A colonoscopy every 10 years; and
4. Any additional medically recognized screening tests for colorectal cancer required by the Director of the Department of Health.

Follow-up screenings are covered as follows:

1. If the initial colonoscopy is normal, follow-up is recommended in 10 years;
2. For Covered Persons with 1 or more neoplastic plyps, adenomatous polyps, assuming that the initial colonoscopy was complete to the cecum and adequate preparation and removal of all visualized polyps follow-up is recommended in 3 years;
3. If single tubular adenoma of less than 1 centimeter (4 for patients with large sessile adenomas greater than 3 centimeters) especially if removed in piecemeal fashion, follow-up is recommended in 6 months or until complete polyp removal is verified by colonoscopy.

Diabetes – Reasonable and Customary Charges for equipment, supplies, medication and a one per lifetime self-management training and patient management, including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin-using diabetes, while Hospital Confined. The self-management diabetes training program must be Medically Necessary as determined by a Doctor. Additional training is covered when a Doctor prescribes the additional training as Medically Necessary because of a significant change in the Covered Person's symptoms or conditions.

EXCEPTIONS

WE DO NOT COVER AN INJURY OR SICKNESS THAT IS EXCLUDED BY NAME OR DESCRIPTION.

THE GROUP POLICY DOES NOT PROVIDE COVERAGE FOR LOSS CAUSED BY, CONTRIBUTED TO, OR RESULTING FROM ANY OF THE FOLLOWING EXCEPTIONS:

1. Injury or Sickness if the loss is covered under these or similar laws:
   worker's compensation ,
   employer's liability, or
   occupational disease laws.

2. Injury or Sickness that results from war or an act of war, whether war is declared or not.

3. Care or supplies that a Covered Person receives in a Hospital or other facility that a government agency runs; however, We will not apply this Exception if:

   (a) The Covered Person receives a charge that he/she has to pay by law, and
   (b) The Hospital or facility would have made the charge even if no insurance existed.

4. The diagnosis and/or treatment of the adenoids, tonsils, gallbladder, reproductive organs, and hernia for the first six months of coverage; however, if We have excluded any one of these conditions by rider, We do not pay any benefit for the condition, regardless of when the treatment takes place; or if such condition is a Preexisting Condition, any benefit consideration will be in accordance with the Preexisting Conditions provision; however, this Exception does not apply to a HIPAA Eligible Individual.

5. Procedures or treatments that are Experimental or Investigational Medicine.

6. Pregnancy and childbirth, except for Complications of Pregnancy.

7. Mental Disorders.

8. Cosmetic surgery however, this Exception does not apply when surgery is required:
   a) To correct damage that results from a covered Injury;
   b) To repair a birth defect of a child born to the Certificateholder and continuously covered under this Policy from its birth; or
   c) For breast reconstruction following a covered mastectomy.

9. Breast reduction and surgery to repair, replace, or remove breast implants;

10. Dental Treatment, unless due to Injury to a Covered Person's natural teeth.

11. A Pre-Existing Condition as defined in the Group Policy, except as stated under DEFIITIONS and TIME LIMIT ON CERTAIN DEFENSES, PRE-EXISTING CONDITIONS.

12. Any attempt at suicide, while sane.

13. An intentionally self-inflicted Injury, while sane.

14. A Covered Person's commission of or attempt to commit a felony, an illegal act, or being engaged in an illegal occupation.

15. A Covered Person being intoxicated, unless such intoxication is the result of a prescription drug taken as prescribed by a Doctor.

16. A Covered Person with a blood alcohol concentration equal to or in excess of .08 gms/dl operating any motor vehicle, including any off-road vehicle, or watercraft.

17. Any procedure for refractive correction, eye refraction or the purchase or fitting of vision or hearing aids, Cochlear Implants and related devices.

18. Weight reduction or treatment of obesity, including exogenous, endogenous, or morbid obesity.

19. Mandibular or maxillofacial surgery to correct growth defects and jaw disproportions or malocclusions; increase vertical dimension; or reconstruct occlusion after one year from a child's date of birth or a child's date of adoption, except where such surgery is for the repair of a congenital anomaly or birth defect of a child born to You or a child that he/she adopts if the child is continuously covered from birth, adoption, or placement for adoption.

20. Treatment provided outside the United States of America, its possessions and territories, except as otherwise provided under Foreign Emergency Treatment.

21. Diagnosis or treatment (including surgery) of sexual dysfunction disorder or inadequacy; or transsexual surgery.

22. Sclerotherapy for veins of the extremities or laser surgery to minimize veins.

23. Routine newborn care.

24. Care in a nursing home or custodial institution; domiciliary care or rest cures.

25. Charges for Medical Services that You or a Covered Person is not legally obligated to pay.

26. Any charges for or relating to: artificial insemination; in-vitro fertilization or any other diagnosis or treatment for the control, promotion, or enhancement of fertility; treatment for impotency; sterilization or reversal of prior sterilization; abortion, unless the life of the mother would be endangered if the fetus were carried to term; or therapeutic abortion.

27. Drugs and supplies provided for home use.

28. Treatment of alcoholism or drug use.

29. False labor; pre-term or premature labor; occasional spotting; prescribed rest while pregnant; morning sickness; hyperemesis gravidarum; or pre-eclampsia. There may be other conditions that relate to a difficult pregnancy that a Doctor can manage.

AUTOMATIC COVERAGE OF NEWBORN AND ADOPTED CHILDREN

Newborns: If the Group Policy provides coverage for Covered Persons other than You, the Policy will also provide coverage for newborn children when they live with You from the moment of birth. This coverage is free for the first 90 days.

Adopted Children: If the Group Policy provides coverage for Covered Persons other than You, the Policy will also provide coverage for adopted children and children who are placed for adoption from the date of the filing of a petition for adoption. This coverage for adopted children is free for the first 60 days of the filing of a petition for adoption if You apply for coverage within 60 days after the filing of the petition for adoption. However, the coverage will be free for the first 60 days from the moment of birth if the petition for adoption and application for coverage is filed within 60 days after the birth of the minor.

In order to continue coverage for a newborn or adopted child, You must do the following:

1. Send Us notice of the child within the 90 days after the date of the child's birth or before the premium due date, whichever is later (or, in the case of an adopted child, within the 60 days after the filing of the petition for adoption or birth of child); and
2. Send Us the additional premium for the child within 90 days of the child's date of birth or within 60 days of the date of petition for adoption or birth of the child.

As long as You pay the extra premium, the child will remain a Covered Person, subject to the Termination of Coverage and Loss of Coverage Eligibility provisions of the Group Policy. Coverage for a child that is placed with You for adoption will continue in accordance with the Termination of Coverage and Loss of Coverage Eligibility provisions, unless the placement is disrupted prior to legal adoption and the child is removed from placement.

We do not require an application for the child unless You have notified Us of the child later than the ~~31 days~~ timeframe as required above.

TERMINATION OF COVERAGE

We can terminate coverage under the Group Policy as of any premium due date under any of the following conditions:

1. You have failed to pay premiums or contributions in accordance with the terms of the Group Policy, or We have not received timely premium payments;
2. You or a Covered Person has performed an act or practice that constitutes fraud with respect to activities under the Group Policy;
3. You no longer reside, live, or work in the PPO service area or in an area where We have authority to do business. We will only apply this provisions if We end coverage uniformly and without regard to any health status related factor of a Covered Person; or
4. We are ceasing to offer coverage in the medical expense market in accordance with applicable state law.

Notice of termination will be provided in accordance with state law.

If coverage under the Group Policy ends and is replaced by a group health insurance plan issued by another insurer or self-funded health care plan, coverage under the Group Policy will continue for any Covered Person who is Hospital Confined on the date coverage under the Group Policy ends. Continuation of such benefits are subject to all terms and conditions the Group Policy, except those relating to termination of benefits. Such benefits will continue until the Hospital Confinement ends or until the maximum benefits available under the Group Policy are paid, whichever occurs first.

Subject to the conditions listed above, We cannot refuse to renew coverage:

1. Just because of a change in a Covered Person's health or the type of work the Covered Person performs; or
2. Just because of the claims filed by or on behalf of a Covered Person, unless the claims are fraudulent.

LOSS OF ELIGIBILITY

Eligibility for continuation of coverage under the Group Policy by a Covered Person ends on the date of the month that coincides with the date of the month shown on the Certificate Schedule and occurs on such date next following the date of the event that causes such termination. If a Covered Person's coverage ends under the Group Policy, in accordance with the paragraphs above, such Person may be eligible for Continuation or Conversion. Please see the Conversion Privilege and the State Continuation Privilege.

RULES FOR ALL COVERED PERSONS - Coverage will end:

1. If the Group Policy is terminated in accordance with the section titled TERMINATION OF COVERAGE; or
2. If You fail to pay the required premium within the time the Grace Period.

RULES FOR ADULT COVERED PERSONS - Coverage will end:

1. For Your spouse if there is a divorce; or
2. If a mentally or physically disabled Covered Person marries or becomes capable of self-support. (See the section titled EXTENSION OF COVERAGE FOR SOME CHILDREN).

If a married Certificateholder dies and his/her spouse is a Covered Person, the spouse will become the Certificateholder.

RULES FOR CHILD COVERED PERSONS - Coverage will end for a child when:

1. The child is no longer a dependent of You;
2. The child gets married; or
3. The child attains the Limiting Age, except for the extension allowed by the section titled EXTENSION OF COVERAGE FOR SOME CHILDREN.

PREMIUM – We will adjust premiums if required under Our rules as of the date coverage ends for a Covered Person. This will occur on a date consistent with the date coverage ends, as described above.

SUCCESSION – If the Certificateholder dies and is survived by other Covered Persons, a new Certificateholder will be named in accordance with the following:

1. If the deceased Certificateholder was married at the time of death and his/her spouse is a Covered Person, the spouse will become the new Certificateholder;

2. If the deceased Certificateholder was married at the time of death and his/her spouse is not a Covered Person, while other Covered Persons survive the deceased Certificateholder, the spouse will become the Certificateholder; or

3. If the deceased Certificateholder was unmarried at the time of death while other Covered Persons survive the deceased Certificateholder, the estate of the deceased Certificateholder shall be entitled to name a new Certificateholder in accordance with the Company's rules in effect on the date of the deceased Certificateholder's death.

EXTENSION OF COVERAGE FOR SOME CHILDREN

When an unmarried dependent child who is a Covered Person has reached the Limiting Age, coverage may continue if the child is, and remains, incapable of sustaining employment by reason of mental retardation or physical disability and who is chiefly dependent upon You for support and maintenance.

ANTEX may ask You to furnish proof of the incapacity or dependency. ANTEX will bear the cost of obtaining such proof. You are expected to notify ANTEX if the incapacity or dependency is removed or terminated in the future.

The premium rate for the handicapped dependent will remain at the child rate.

TOTAL DISABILITY

"Total Disability" means a Covered Person's inability, because of Sickness or Injury, to perform the material and substantial duties of his/her occupation.

If a Covered Person suffers from Total Disability at the time of any termination or discontinuance of this Policy by ANTEX, regardless of the reason for the termination or discontinuance, ANTEX will provide an extension of benefits for a period of 12 months immediately following the date of termination or discontinuance. Benefits payable will be subject to this Policy's regular benefit limits.

CONVERSION PRIVILEGE

If coverage under the Group Policy has been terminated, Covered Persons are entitled to have a conversion policy issued by ANTEX, without evidence of insurability, subject to the following terms and conditions:

1. A conversion policy is not available to a Covered Person if termination of his insurance under the Group Policy occurs:
   a) Because he/she failed to make timely payment of any required premium; or
   b) For any other reason, and he/she had not been continuously covered under the Group Policy, and for similar benefits under any group policy which it replaced, during the entire three (3) months period ending with such termination; or
   c) Because the Group Policy terminated and the insurance was replaced by similar coverage under another group policy within thirty-one (31) days of the date of termination; and

2. Written application and the first premium payment for the conversion policy shall be made to ANTEX not later than thirty-one (31) days after such termination.

The premium for the conversion policy shall be determined in accordance with ANTEX's table of premium rates applicable to the age and class of risk of each person to be covered under that policy and to the type and amount of insurance provided.

The conversion policy shall cover the Covered Persons on the date his/her coverage terminates under the Group Policy. At the option of ANTEX, a separate conversion policy may be issued to cover any dependent. ANTEX shall not be required to issue a conversion policy covering any person if such person is or could be covered by Medicare. Furthermore, ANTEX shall not be required to issue a conversion policy covering any person if:

1. Such person is or could be covered for similar benefits under an individual policy; such person is or could be covered for similar benefits under any arrangement of coverage for an individual in a group, whether insured or uninsured; or similar benefits are provided for or available to such person by reason of any state or federal law; and

2. The benefits under sources described in paragraph (1) above for such person, or benefits provided or available under sources described in paragraph (1) above for such person, together with the conversion policy's benefits would result in overinsurance according to ANTEX's standards for overinsurance.

The conversion policy will not exclude, as a Pre-Existing Condition, any condition covered by the Group Policy; provided, however, that the conversion policy may provide for a reduction of its hospital, surgical, or medical benefits by the amount of any such benefits payable under the Group Policy after the individual's insurance terminates.

STATE CONTINUATION PRIVILEGE

If coverage ends under the Group Policy for certain reasons, a Covered Person may be able to continue his coverage.

CONTINUATION:

A Covered Person may continue his coverage under the Group Policy and that of his dependents who are covered under the Group Policy if his coverage would otherwise end because of termination of membership or because of a change in marital status. Such coverage will be continued if the person:

1. Has been continuously covered under the Group Policy for the 3 month period prior to termination of membership or change in marital status; and

2. Is not eligible for Medicare or is not fully covered (i.e., all Pre-Existing Conditions are covered) under any other group medical policy or contract;

Continuation will be allowed under this provision until all Pre-Existing Conditions are covered or would be covered under another group policy or contract or until termination pursuant to this continuation provision or pursuant to any applicable provision of federal law.

To continue coverage, the person must request continuation in writing within 10 working days of termination of membership or change in marital status. Premiums must be p[aid on a monthly basis in advance in accordance with the terms of the Group Policy.

This continuation will end on the earliest of the following dates:
1. 120 days from the date continuation began;
2. The end of the period for which premiums are paid on a timely basis;
3. The premium due date following the date the person becomes eligible for Medicare;
4. The date maximum benefits available under the Group Policy are paid for such person; or
5. The date of termination of the Group Policy; however, continuation will continue under any replacement policy.

Upon termination of this continuation, the person may have the right of conversion described above. Any person who elects the conversion privilege waives the right to this continuation.

COORDINATION OF BENEFITS

The Coordination of Benefits (COB) provision applies when a Covered Person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans does not exceed 100% of the total Allowable expense.

DEFINITIONS

A. A **Plan** is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts:

(1) **Plan** includes: group and nongroup insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

(2) **Plan** does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

B. **"This Plan"** means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. The order of benefit determination rules determine whether This plan is a Primary plan or Secondary plan when the Covered Person has health care coverage under more than one Plan.

When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

D. Allowable expense is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the Covered Person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering the Covered Person is not an Allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered Covered Person is not an Allowable expense.

The following are examples of expenses that are not Allowable expenses:

(1) The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.

(2) If a Covered Person is covered by 2 or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.

(3) If a Covered Person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.

(4) If a Covered Person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary plan's payment arrangement shall be the Allowable expense for all Plans. However, if the provider has contracted with the Secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary plan to determine its benefits.

(5) The amount of any benefit reduction by the Primary plan because a Covered Person has failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

E. Closed panel plan is a Plan that provides health care benefits to Covered Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

F. Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When a Covered Person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

A. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.

B. (1) Except as provided in Paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary.

(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide out-of-network benefits.

C. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

D. Each Plan determines its order of benefits using the first of the following rules that apply:

(1) Non-Dependent or Dependent. The Plan that covers the Covered Person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary plan and the Plan that covers the Covered Person as a dependent is the Secondary plan. However, if the Covered Person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the Covered Person as a dependent; and primary to the Plan covering the Covered Person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the Covered Person as an employee, member, policyholder, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.

(2) Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

(i.) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or
(ii.) If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.

(b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(i.) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
(ii.) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;
(iii.) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or
(iv.) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

1. The Plan covering the Custodial parent;
2. The Plan covering the spouse of the Custodial parent;
3. The Plan covering the non-custodial parent; and then
4. The Plan covering the spouse of the non-custodial parent.

(c) For a dependent child covered under more than one Plan of individuals who are the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

(3) Active Employee or Retired or Laid-off Employee. The Plan that covers a Covered Person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same Covered Person as a retired or laid-off employee is the Secondary plan. The same would hold true if a Covered Person is a dependent of an active employee and that same Covered Person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(4) COBRA or State Continuation Coverage. If a Covered Person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the Covered Person as an employee, member, subscriber or retiree or covering the Covered Person as a dependent of an employee, member, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(5) Longer or Shorter Length of Coverage. The Plan that covered the Covered Person as an employee, member, policyholder, subscriber or retiree longer is the Primary plan and the Plan that covered the Covered Person the shorter period of time is the Secondary plan.

(6) If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This plan will not pay more than it would have paid had it been the Primary plan.

EFFECT ON THE BENEFITS OF THIS PLAN

A. When This plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary plan. The Secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim. In addition, the Secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If a Covered Person is enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed panel plan, COB shall not apply between that Plan and other Closed panel plans.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This plan and other Plans. ANTEX may get the facts it needs from or give them to other organizations or Covered Persons for the purpose of applying these rules and determining benefits payable under This plan and other Plans covering the Covered Person claiming benefits. ANTEX need not tell, or get the consent of, any person to do this. Each Covered Person claiming benefits under This plan must give ANTEX any facts it needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another Plan may include an amount that should have been paid under This plan. If it does, ANTEX may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This plan. ANTEX will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by ANTEX is more than it should have paid under this COB provision, it may recover the excess from one or more of the Covered Persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the Covered Person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

GENERAL PROVISIONS

ENTIRE CONTRACT -- The Entire Contract will consist of:

1. The Group Policy;
2. The Application of the Group Policyholder, which will be attached to the Group Policy;
3. Any Enrollment Applications and attached papers for the proposed Covered Persons; and
4. Any riders, endorsements or amendments issued with or added to the Group Policy or any Certificate which is a part of the Group Policy.

We will deem all the statements provided in the Enrollment Application and attached supplements, except fraudulent statements, as representations and not warranties.

TIME LIMIT ON CERTAIN DEFENSES --

1. MISSTATEMENTS IN THE ENROLLMENT APPLICATION --
We may only use fraudulent misstatements in the Enrollment Application to void coverage under the Group Policy or to deny any claim for loss incurred more than 24 months after the Covered Person's Certificate Date.

2. PRE-EXISTING CONDITIONS --
No claim for loss incurred after the earlier of: (a) the end of a continuous period of 12 months commencing on or after the Covered Person's effective date of coverage under the Group Policy, during which the Covered Person has received no medical advice or treatment in connection with such disease or physical condition or (b) the end of the 2-year period commencing on the effective date of the Covered Person's coverage under the Group Policy will be reduced or denied unless:

(a) The disease or physical condition has been excluded from coverage by name or specific description, and;
(b) Such exclusion is in effect on the date the loss is incurred.

REINSTATEMENT -- Coverage terminates if You do not pay a periodic premium payment before the end of the Grace Period. Our later acceptance of premium, (or one of our authorized agent's acceptance of premium) without requiring an application for reinstatement, reinstates coverage under the Group Policy.

We will require an application for reinstatement. We will subject all representations made in this application to all of the provisions of the Group Policy, including TIME LIMIT ON CERTAIN DEFENSES. If We approve the application for reinstatement, We will reinstate coverage as of the approval date of the reinstatement Enrollment Application. If We do not approve the reinstatement and do not notify You in writing of the disapproval, We must reinstate coverage. The reinstatement will take place on the 45th day following the date of Our receipt of the application for reinstatement.

The reinstated plan only covers loss resulting from:

1. Injury that occurs after reinstatement; and
2. Sickness that begins ten days or more after the Covered Person's date of reinstatement.

In all other respects, the Covered Person's rights and Our rights will remain the same, except as stated in any application attached to the reinstated coverage.

We will apply any premiums that We accept for reinstatement to a period for which You have not paid premiums. We will not apply any premium to any period more than 60 days before the reinstatement date.

WE WILL NOT CONSIDER A REQUEST FOR REINSTATEMENT THAT YOU MAKE MORE THAN 180 DAYS AFTER COVERAGE UNDER THE GROUP POLICY HAS TERMINATED.

GRACE PERIOD -- There is a 31 day grace period for the payment of any premium. If a renewal premium is not paid on or before its due date, it may be paid during the following 31 days. If We do not receive the payment during this Grace Period, We will terminate coverage. Termination will be effective as of the end of the period for which

premium was paid. The Grace Period does not apply if the Company has provided a notice of intent to terminate the Group Policy.

NOTICE OF CLAIMS -- A claimant must give notice of claim within 30 days after a covered loss starts or as soon as reasonably possible. The claimant must give the notice to Us at Our Home Office in Galveston, Texas. The notice must include the claimant's name and his/her Certificate Number.

CLAIM FORMS -- When We receive notice of claim, We will send the claimant forms for filing Proof of Loss. If We do not mail the claimant these forms within 15 days of Our receipt of his/her request, the claimant will have met the Proof of Loss requirement. However, the claimant must still give Us a written statement of the nature and extent of the loss within the time limit stated in the Proof of Loss section.

PROOFS OF LOSS -- The claimant must give written Proof of Loss to the Home Office in Galveston, Texas within 90 days after such loss. If it was not reasonably possible for the claimant to give the Proof of Loss in the time required, We will not reduce or deny the claim as long as the claimant gives proof as soon as reasonably possible. In any event, the claimant must give proof no later than 1 year from the time specified, unless the claimant was legally incapacitated.

TIME FOR PAYMENT OF CLAIMS -- All benefits payable under the Group Policy will be paid immediately upon receipt of Proof of Loss.

We will pay or deny each Clean Claim as follows: (1) if the claim is filed electronically, within 30 days after the date We receive the claim; or (2) if the claim is filed on paper, within 45 days after the date we receive the claim. We will notify the claimant of any deficiencies in the claim not less than 30 days after the date We receive the claim. The notice will give an explanation of any additional information required. We will suspend the claim until We receive the requested information. We will reopen and pay or deny the suspended claim within 30 days after We receive the information requested..

If We fail to pay or deny a Clean Claim or to give notice that We need more information to pay a claim, We will pay the claimant for the period beginning on the 61st day after receipt of the Clean Claim and ending on the Clean Claim payment date (this is called the delinquent payment period), calculated as follows: the amount of the Clean Claim payment times 12% per annum times the number of days in the delinquent payment period, divided by 365. We will pay this penalty without any action by the claimant.

A "Clean Claim" means a claim for payment of health care expenses that is submitted on a HCFA 1500 on a UB92 in a format required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), or on Our standard claim form with all required fields completed in accordance with Our published claim filing requirements. A Clean Claim does not include a claim (1) for payment of expenses incurred during a period of time for which premiums are delinquent; or (2) for which We need additional information in order to resolve the claim.

PAYMENT OF CLAIMS -- We will pay Group Policy benefits to You. If You have assigned benefits, We will pay the benefits to the respective assignee. If You have died, We will pay any unpaid benefits to Your estate. We may pay benefits up to [$1,000] to someone related to You by blood or marriage or to any other person We deem entitled to the benefits if:

1. A court has deemed You incompetent; or
2. You have died and Your estate is not able to execute a valid release.

NO ASSUMPTION OF LIABILITY -- Our payment of any claim does not mean We have assumed liability for future payments for the same condition or any related condition once:

1. We determine that no Medical Service charges exist; or
2. We determine that Our payment was erroneous or inappropriate.

PHYSICAL EXAMINATIONS -- We have the right to have any Covered Person examined as often as reasonably required while a claim is pending for that person. We will pay for the requested physical examination.

LEGAL ACTIONS -- No legal action may be brought to recover on the Group Policy within 60 days after a claimant gives written Proof of Loss. No legal action may be brought after 3 years from the time the Group Policy requires written proof of loss.

LIMITATION OF LIABILITY: You agree that Our liability arising under the Group Policy or in any way related to it is limited to:

(a) Group Policy benefits otherwise payable;
(b) Your reasonable attorneys fees, if any; and
(c) Any statutory penalties that may be imposed.

TERMINATION OF THE GROUP POLICY -- ANTEX or the Group Policyholder may terminate the Group Policy, as described under **TERMINATION OF COVERAGE**, provided written notice is provided 31 days in advance to the other party.

MISSTATEMENTS OF AGE -- If a Covered Person has misstated his/her age, the benefits will be those the premium paid would have purchased if the correct age had been disclosed. However, if on the Certificate Date, We would not have granted coverage because of the Covered Person's correct age, We are only liable for the return of any premiums paid on account of such person.

CONFORMITY WITH STATE STATUTES -- Any provision of the Group Policy which, on the Certificate Date, is in conflict with the laws of the state in which You reside on that date is amended to conform to the minimum requirements of the laws of the state.

ILLEGAL OCCUPATION -- We will not be liable for any loss that results from a Covered Person engaging in an illegal occupation or committing or attempting to commit a felony.

ASSIGNMENT -- No assignment of interest under the Group Policy will be binding upon ANTEX unless and until We receive the original or a duplicate of the assignment at Our Home Office in Galveston, Texas. Any assignment will be subject to any right of offset that We may be entitled to assert. We are not responsible for the validity or sufficiency of any assignment. If We pay the assignor, We are not liable for payment to the assignee.

AUTHORITY, AMENDMENT, AND ALTERATION -- Neither ANTEX nor the Group Policyholder may modify any terms of the Group Policy except by a written agreement signed by one of Our officers. Neither ANTEX nor the Group Policyholder may waive any forfeiture under the Group Policy except by a written agreement signed by one of Our officers. ANTEX may not delegate the authority for the purposes of this provision. ANTEX may amend or change the Group Policy at any time, subject to the laws of the jurisdiction in which We delivered the Group Policy. In this case, We may amend or change the Group Policy by written agreement between the Group Policyholder and Us and without the consent of the Covered Persons or his/her beneficiaries, if any. No agent has the authority to waive an answer to any question in the application, determine insurability, make or alter any contract or waive any of ANTEX's other rights or requirements. No change in the Group Policy will be valid unless evidenced by endorsement on the Group Policy or by a signed amendment to the Group Policy.

ELECTRONIC ACCOUNT DEBIT AUTHORIZATION -- If You have chosen Electronic Account Debit as Your method of payment, You agree that:

1. We are authorized to debit Your named account for required payments;
2. The account debit will be made electronically without the signature of any officer or employee of ANTEX;
3. We will not provide a receipt for any account debit;
4. ANTEX will not incur any liability because of dishonor of the account debit;
5. Upon refusal of the financial institution to honor any attempted debit of the named account, We will cease to debit Your account. We will send You written notice requesting payment in full of the required premium. Upon Your payment of the required premium, We will again begin to debit Your account. However, if You do not pay the required premium, Your coverage will lapse in accordance with the Grace Period provision; and
6. Except as provided in (4) above, the authorization remains effective unless either party ends the authorization. Before ending the authorization, a party must provide the other party at least 30 days advance written notice. We are not liable for amounts debited from Your account prior to Our receipt of written notification to end coverage.

DIRECT PAYMENT TO PUBLIC HOSPITALS AND CLINICS -- Benefits to a Covered Person shall be paid, with or without an assignment from the Covered Person, to public Hospitals or clinics for services and supplies provided to the Covered Person if a proper claim is submitted by the public Hospital or clinic. No benefits shall be paid under this provision to the public Hospital or clinic if such benefits have been paid to the Covered Person prior to receipt of the claim by ANTEX. Payment to the public Hospital or clinic of benefits pursuant to this provision shall discharge ANTEX from all liability to the Covered Person to the extent of the benefits so paid. Nothing in this provision shall be construed to require payment of benefits for the same services or supplies to both the Covered Person and the public Hospital or clinic.

NOTICE TO CERTIFICATEHOLDERS: We are here to serve the Certificateholder. As our Certificateholder, Your satisfaction is very important to Us. If You have a question about Your Certificate, if You need assistance with a problem, or if You have a claim, You should first contact Your insurance agent or Us at 1-800-899-6520. If You do not have Your agent's name, address, or phone number, please contact Us and We will be able to supply the information.

If We at ANTEX fail to provide You with reasonable and adequate service, You should feel free to contact:

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, AR 72201-1904
1-800-852-5494

EXTERNAL REVIEW PROCEDURE – In certain cases, the Certificateholder has the right to request an External Review Procedure, as described in this Section.

The following terms are defined:

Adverse Determination means the Company's determination that an admission, availability of care, continued stay or other Medical Service has been reviewed and, based upon the information provided, the requested payment for the service is denied, reduced or terminated, because:

(a) The requested Health Care service does not meet the Company's requirements for Medical Necessity, or
(b) The requested Health Care service has been found to be "Experimental/Investigational."

In order to qualify as an "Adverse Determination:"

(a) The Adverse Determination must be a Final Adverse Determination, except as may be provided herein.
(b) The Adverse Determination must involve treatment, services, equipment, supplies, or drugs that would require the health benefit plan to expend five hundred dollars ($500) or more of expenditures.

Adverse Determination does not include the Company's determination to deny a Health Care service based upon:

(a) An express exclusion in the health benefit plan other than a general exclusion for "Medical Necessity" or "Experimental/Investigational;"
(b) An express limitation in the health benefit plan with respect to the number of visits, treatments, supplies or services for a covered benefit in a given calendar period or over the lifetime of the Covered Person;
(c) An express limitation in the health benefit plan with respect to a maximum dollar limitation with respect to a covered benefit in a given calendar period or over the lifetime of the Covered Person;
(d) the Company's determination that an individual is not eligible to be a Covered Person;
(e) the Company's determination that treatment, service, or supplies were requested or obtained by a Covered Person through fraud or material misrepresentation.
(f) The health benefit plan's procedure for determining the Covered Person's access to a Health Care Provider, including but not limited to a network access provision;
(g) Illegality of services or the means or methods of administering them;
(h) FDA or other government agency determinations, reports or statements; or
(i) Licensure, permit or accreditation status of a Health Care Provider.

Authorized Representative means:

(a) A person to whom a Covered Person has given express written consent to represent the Covered Person in an External Review;
(b) A person authorized by law to provide substituted consent for a Covered Person; or
(c) When the Covered Person is unable to provide consent, a family member of the Covered Person or the Covered Person's treating Health Care Professional if a family member is unavailable.

Commissioner means the Arkansas Insurance Commissioner.

Covered Benefits or Benefits means those Health Care services to which a Covered Person is entitled under the terms of a health benefit plan.

Covered Person means You. Covered Person shall also mean the Covered Person's Authorized Representative, as defined in this regulation.

Disclose means to release, transfer or otherwise divulge protected Health Information to any person other than the individual who is the subject of the protected Health Information.

Emergency Medical Condition means medical conditions of a recent onset and severity, including, but not limited to, severe pain that would lead a prudent lay person, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

Emergency Services means Health Care items and services furnished or required to evaluate and treat an Emergency Medical Condition.

External Review means a process, independent of all affected parties, to determine if a Health Care service is medically necessary or experimental/ investigational.

Facility means an institution providing Health Care services or a Health Care setting, including but not limited to, hospitals and other licensed inpatient centers, outpatient surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

Final Adverse Determination means an Adverse Determination involving a covered benefit that has been upheld by a health carrier at the completion of the health carrier's internal grievance procedure or Utilization Review procedure. If the health carrier does not have, nor is required by law to have, an internal grievance procedure or Utilization Review procedure, an Adverse Determination shall be considered a Final Adverse Determination.

Health care professional means a physician or other Health Care practitioner licensed, accredited or certified to perform specified health services consistent with state law.

Health Care Provider or Provider means a Health Care Professional or a Facility.

Health Care Services means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.

Health Information means information or data, whether oral or recorded in any form or medium, and personal facts or information about events or relationships that relates to:

(a) The past, present or future physical, mental, or behavioral health or condition of an individual or a member of the individual's family;

(b) The provision of Health Care services to an individual; or

(c) Payment for the provision of Health Care services to an individual.

Independent Review Organization means an entity that conducts independent External Reviews of Adverse Determinations and Final Adverse Determinations.

Medical or Scientific Evidence means the following sources:

(a) Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;
(b) Peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the National Institutes of Health's Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline and MEDLARS database Health Services Technology Assessment Research (HSTAR);
(c) Medical journals recognized by the Secretary of Health and Human Services under Section 1861(t)(2) of the federal Social Security Regulation;

(d) The following standard reference compendia: The American Hospital Formulary Service-Drug; The American Dental Association Accepted Dental Therapeutics; and The United States Pharmacopoeia-Drug Information;

(e) Findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including: The federal Agency for Healthcare Research and Quality; The National Institutes of Health; The National Cancer Institute; The National Academy of Sciences; The Centers for Medicare and Medicaid Services; Any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of Health Care services; and Any other Medical or Scientific Evidence that is comparable to the sources listed in Subparagraphs (a) through (e).

Medical or Scientific Evidence shall not include published peer-reviewed literature sponsored to a significant extent by a pharmaceutical manufacturing company or medical device manufacturer.

Medically Necessary or Medical Necessity has the same definition as found under the section of the Certificate titled **DEFINITIONS.**

Person means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, a limited liability company, any similar entity or any combination of the foregoing.

Protected Health Information means Health Information that is not subject to disclosure under state and/or federal law.

Retrospective Review means a review of Medical Necessity conducted after services have been provided to a patient, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication for payment.

Utilization Review and Utilization Review Procedure mean the system for reviewing the appropriate and efficient allocation of hospital resources and medical services given or proposed to be given to a patient or group of patients.

Requesting an External Review, General Information - At the time of an Adverse Determination or a Final Adverse Determination, the Company will notify the Covered Person and Health Care Professional in writing of the right to request an External Review.

Before filing a request for an External Review, a Covered Person must exhaust the Company's internal grievance procedures (unless the Company waives this requirement). A Covered Person has exhausted the internal grievance procedure when:

(a) The Covered Person has filed an appeal regarding an Adverse Determination with the Company; and
(b) The Covered Person has not received a written decision on the appeal from the Company within 30 days following the date the Covered Person filed the appeal. (This 30 day requirement does not apply if the Covered Person requested or agreed to a delay of the 30 day requirement); or
(c) The Covered Person has received a written decision regarding the appeal and the Company has made a Final Adverse Determination.

Once the Covered Person has received a Final Adverse Determination, the Covered Person has 60 days to request of External Review. The Covered Person must request an External Review in writing.

When requesting an External Review, the Covered Person will be required to authorize the release of any medical records that may be required for review in making the decision on the External Review. the Company will attach the authorization form to the External Review Notice.

A Covered Person has the right to contact the Commissioner for assistance with the External Review process at any time. The Commissioner's contact information is:

Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201
(501)371-2600 or 1-800-282-9134
insurance.Consumers@Arkansas.gov

Standard External Review – When the Company receives a request for an External Review, it will assign an Independent Review Organization (IRO) to the External Review.

The IRO will conduct a preliminary review to determine if:

(1) The request meets External Review requirements;
(2) The Covered Person has exhausted the Company's internal grievance process (unless the Covered Person is not required to exhaust the grievance process as described in this notice); and
(3) The Covered Person has provided all information and forms required to process an External Review, including the authorization form that the Company provided at the time of the Adverse or Final Adverse determination.

Within 5 business days, the IRO will review the Request and notify the Covered Person whether the request is complete and whether the IRO has accepted the Request. Within 7 business days after the date of receipt of this IRO notice, the Company will provide to the IRO, the Covered Person, and the Covered Person's treating Health Care Professional the documents and any information considered in making the Adverse Determination or Final Adverse Determination, together with any additional information required.

The IRO notice will include a statement that the Company, the Covered Person and the Covered Person's treating Health Care Professional may submit additional information and supporting documentation in writing to the IRO within 7 business days following the date of receipt of the notice. The IRO will consider this information when conducting the External Review. The IRO shall review all of the information and documents received in writing by the Covered Person, the Covered Person's treating Health Care Professional, and the Company.

If the request is not complete, the assigned IRO will, within 5 business days, inform the Company, the Covered Person, and the Covered Person's treating Health Care Professional what information or materials are needed to make the request complete. The IRO will immediately forward copies of any additional information to the Company.

If the request is not accepted for External Review, the assigned IRO will inform the Covered Person, the Covered Person's treating Health Care Professional and the Company in writing within 5 business days of the reasons for its nonacceptance.

In reaching a decision to accept or reject a matter for External Review, the IRO is not bound by any decisions or conclusions reached during the Company's internal grievance procedure or Utilization Review procedure.

Except in the case of the IRO terminating and reversing the Company's Adverse Determination or Final Adverse Determination because the Company failed to provide documents and information to the IRO within an acceptable time frame, failure by the Company or its Utilization Review organization to provide the documents and information within the time frame required will not delay the conduct of the External Review.

If the Company or its Utilization Review Organization fails to provide the documents and information within the time frame required, the IRO may terminate the External Review and make a decision to reverse the Adverse Determination or Final Adverse Determination.

Upon receipt of the information, if any, required to be forwarded to the IRO, the Company may reconsider its Adverse Determination or Final Adverse Determination that is the subject of the External Review.

Reconsideration by the Company of its Adverse Determination or Final Adverse Determination will not delay or terminate the External Review.

The External Review may only be terminated if the Company decides, upon completion of its reconsideration, to reverse its Adverse Determination or Final Adverse Determination and provide coverage or payment for the Health Care service that is the subject of the Adverse Determination or Final Adverse Determination.

Immediately upon making the decision to reverse its Adverse Determination or Final Adverse Determination, the Company shall notify the Covered Person, the Covered Person's treating Health Care Professional, and the IRO in writing of its decision.

The IRO will terminate the External Review upon receipt of the notice from the Company regarding its reversal.

In addition to the documents and information referred to above, the IRO, to the extent the information or documents are available and the IRO considers them appropriate, shall consider the following in reaching a decision:

(1) The Covered Person's medical records;
(2) The treating Health Care Professional's recommendation;
(3) Consulting reports from appropriate Health Care Professionals and other documents submitted by the health carrier, Covered Person, or the Covered Person's treating Health Care Professional;
(4) The most appropriate practice guidelines, which may include generally accepted practice guidelines, evidence-based practice guidelines or any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;
(5) Any applicable written screening procedures, decision abstracts, clinical protocols and practice guidelines used by a health carrier to determine the necessity and appropriateness of Health Care services;
(6) If the Adverse Determination involves a denial of coverage based on a determination that the recommended or requested Health Care services is "experimental" or "investigational," the IRO shall also consider whether:
    (a) The recommended or requested Health Care service or treatment has been approved by the federal Food and Drug Administration for the condition, while realizing that treatments or services are often legitimately used for purposes other than those listed in the FDA approval; or
    (b) Medical or scientific evidence demonstrates that the expected Benefits of the recommended or requested Health Care service or treatment is more likely than not to be more beneficial to the Covered Person than any available standard Health Care service or treatment and the adverse risks of the recommended or requested Health Care service or treatment would not be substantially increased over those of available standard Health Care services or treatments.

Within 45 calendar days after the date of receipt of the request for an External Review, the IRO shall provide written notice of its decision to uphold or reverse the Adverse Determination or the Final Adverse Determination to the Covered Person, the Covered Person's treating Health Care Professional, and the Company.

The IRO notice will include:

(a) A general description of the reason for the request for External Review;
(b) The date the IRO received the assignment from the health carrier to conduct the preliminary review of the External Review request;
(c) The date the External Review was conducted, if appropriate;
(d) The date of its decision;
(e) The principal reason or reasons for its decision;
(f) The rationale for its decision; and
(g) References to the evidence or documentation, including the practice guidelines, considered in reaching its decision.

If the Adverse Determination involves a denial of coverage based on a determination that the recommended or requested Health Care services is "experimental" or "investigational," the IRO shall also consider whether:

(i) A description of the indicators relevant to determining whether there is sufficient evidence to demonstrate that the recommended or requested Health Care service or treatment is more likely than not to be more beneficial to the Covered Person than any available standard Health Care services or treatments and the adverse risks of the recommended or requested Health Care service or treatment would not be substantially increased over those of available standard Health Care services or treatments; and

(ii) A description and analysis of any Medical or Scientific Evidence considered in reaching the opinion.

Upon receipt of a notice of a decision reversing the Adverse Determination or Final Adverse Determination, the Company will immediately approve the coverage that was the subject of the Adverse Determination or Final Adverse Determination.

The assignment by the Company of an approved IRO to conduct an External Review in accordance with this section shall be fair and impartial. the Company and the IRO shall comply with standards approved by the Commissioner to ensure fairness and impartiality in the assignment by health carriers of approved IRO to conduct External Reviews.

Expedited External Review – A Covered Person may make a request for an Expedited External Review at the time the Covered Person receives an Adverse Determination or a Final Adverse Determination.

The Covered Person may request an expedited External Review of an Adverse Determination if:

(a) The Covered Person has a medical condition where the timeframe for completion of an expedited review of an appeal set forth in the Company's internal grievance procedure or Utilization Review procedure would seriously jeopardize the life or health of the Covered Person or would jeopardize the Covered Person's ability to regain maximum function; or
(b) The Adverse Determination involves a denial of coverage based on a determination that the recommended or requested Health Care service or treatment is "experimental" or "investigational," and the Covered Person's treating physician certifies in writing that the recommended or requested Health Care service or treatment would be significantly less effective if not promptly initiated.

Note: A Covered Person may file a request for an expedited External Review at the same time the Covered Person files a request for an expedited review of an appeal under the Company's grievance or utilization review procedure if:

(a) The Covered Person has a medical condition where the timeframe for completion of an expedited review of an appeal set forth in the Company's internal grievance procedure or utilization review procedure would seriously jeopardize the life or health of the Covered Person or would jeopardize the Covered Person's ability to regain maximum function; or
(b) The Adverse Determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is "experimental" or "investigational," and the Covered Person's treating physician certifies in writing that the recommended or requested health care service or treatment would be significantly less effective if not promptly initiated.

The IRO will determine whether the Covered Person shall be required to complete the Company's expedited internal grievance procedure or Utilization Review procedure before it conducts the expedited External Review. Upon a determination that the Covered Person must first complete the expedited internal grievance review procedure or Utilization Review procedure, the IRO immediately shall notify the Covered Person and the Covered Person's treating Health Care Professional of this determination and that it will not proceed with the expedited External Review until the expedited internal grievance procedure or Utilization Review procedure is completed and the Adverse Determination or Final Adverse Determination is upheld.

The Covered Person may request an expedited External Review of a Final Adverse Determination if:

(a) The Covered Person has a medical condition where the timeframe for completion of a standard External Review would seriously jeopardize the life or health of the Covered Person, or would jeopardize the Covered Person's ability to regain maximum function; or
(b) The Final Adverse Determination concerns:

(i) An admission, availability of care, continued stay or Health Care service for which the Covered Person received Emergency Services, but has not been discharged from a Facility; or

(ii) A denial of coverage based on a determination that the recommended or requested Health Care service or treatment is experimental or investigational, and the Covered Person's treating physician certifies in writing that the recommended or requested Health Care service or treatment that is the subject of the request would be significantly less effective if not promptly initiated.

At the time the Covered Person makes a request for an expedited External Review, the Covered Person or the Covered Person's treating Health Care Professional shall submit additional information and supporting documentation that the IRO will consider when conducting the expedited External Review.

At the time the Company receives a request for an expedited External Review, the Company will immediately assign an IRO to the case.

At the time the Company assigns an IRO to conduct the expedited External Review, the Company shall immediately provide or transmit all documents and information considered in making the Adverse Determination or

Final Adverse Determination, as well as any additional information and supporting documentation, to the IRO, the Covered Person, and the Covered Person's treating Health Care Professional via electronically, facsimile or any other available expeditious method.

The IRO will, as expeditiously as the Covered Person's medical condition or circumstances require, but in no event more than 72 hours after the date of receipt of the request for an acceptable expedited External Review:

(a) Make a decision to uphold or reverse the Adverse Determination or Final Adverse Determination; and
(b) Notify the Covered Person, the Covered Person's treating Health Care Professional, and the Company of the decision.

If the notice from the IRO was not in writing, within 2 days after the date of providing that notice, the IRO shall:

(a) Provide a written or electronic media confirmation of the decision to the Covered Person and the Company; and
(b) Include the information required for a Standard External Review Notice.

In reaching a decision, the IRO is not bound by any decisions or conclusions reached during the health carrier's Utilization Review process or the Company's internal grievance process.

Upon receipt of notice of a decision reversing the Adverse Determination or Final Adverse Determination, the Company will immediately approve the coverage that was the subject of the Adverse Determination or Final Adverse Determination.

An expedited External Review may not be provided for adverse or Final Adverse Determinations involving a Retrospective Review.

Binding Nature of External Review Decision -

(a) An External Review decision is binding on the Company except to the extent the Company has other remedies available under applicable federal or state law.

(b) An External Review decision is binding on the Covered Person except to the extent the Covered Person has other remedies available under applicable federal or state law.

(c) A Covered Person may not file a subsequent request for External Review involving the same Adverse Determination or Final Adverse Determination for which the Covered Person has already received an External Review decision pursuant to this regulation.

Filing Fees –

(a) Except in the case of a request for an expedited External Review, at the time of filing a request for External Review, the Covered Person shall submit to the IRO a filing fee of $25 along with the information and documentation to be used by the IRO in conducting the External Review.

(b) Upon application by the Covered Person, the Commissioner may waive the filing fee upon a showing of undue financial hardship.

(c) The filing fee shall be refunded to the person who paid the fee if the External Review results in the reversal, in whole or in part, of the Company's Adverse Determination or Final Adverse Determination that was the subject of the External Review.

(d) the Company against which a request for a standard External Review or an expedited External Review is filed shall pay the cost of the IRO for conducting the External Review.

AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS
HOME OFFICE: ONE MOODY PLAZA
GALVESTON, TEXAS

GROUP HOSPITAL INSURANCE CERTIFICATE

THE GROUP POLICY PROVIDES COVERAGE FOR HOSPITAL EXPENSES DESCRIBED IN THE GROUP POLICY AND THIS CERTIFICATE. WHEN SELECTED, A PREFERRED PROVIDER COMPONENT IS INCLUDED WITH THIS COVERAGE.

AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS
(Herein referred to as: ANTEX, the Company, We, Our or Us)
HOME OFFICE: ONE MOODY PLAZA
GALVESTON TEXAS

MASTER POLICY AMENDMENT ARKANSAS RESIDENTS

DEFINITIONS

The following definitions are revised:

COMPLICATIONS OF PREGNANCY means:

1. conditions, requiring Hospital confinement (when the pregnancy is not terminated), whose diagnosis are distinct from pregnancy, but are adversely affected by pregnancy or are caused by pregnancy, such as (1) acute nephritis; (2) nephrosis; (3) cardiac decompensation;(4) HELLP syndrome; (5) uterine rupture; (6) amniotic fluid embolism; (7) chorioamnionitis; (8) fatty liver in pregnancy; (9) septic abortion; (10) placenta accreta; (11) gestational hypertension; (12) puerperal sepsis; (13) peripartum cardiomyopathy; (14) cholestasis in pregnancy; (15) thrombocytopenia in pregnancy; (16) placenta previa; (17) placental abruption; (18) acute cholecystitis and pancreatitis in pregnancy; (19) postpartum hemmorrhage; (20) septic pelvic thromboplebitis; (21) retained placenta; (22) venous air embolus associated with pregnancy; (23) miscarriage; or (24) an emergency c-section required because of (a) fetal or maternal distress during labor, or (b) severe pre-eclampsia, or (c) arrest of descent or dilitation, or (d) obstruction of the birth canal by fibroids or ovarian tumors, or (e) necessary because of the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that, in the absence of immediate medical attention, will result in placing the life of the mother or fetus in jeopardy. A c-section delivery is not considered to be an emergency c-section if it is merely for the convenience of the patient and/or doctor or solely due to a previous c-section; and

2. Treatment, diagnosis or care for conditions, including the following, when the condition was caused by, necessary because of, or aggravated by the pregnancy: (1) hyperthyroidism, (2) hepatitis B 0r C, (3) HIV (4) Human papilloma virus, (5) abnormal PAP, (6) syphilis, (7) chlamydia, (8) herpes, (9) urinary tract infections, (10) thromboembolism, (11) appendicitis, (12) hypothyroidism, (13) pulmonary embolism, (14) sickle cell disease, (15) tuberculosis, (16) migraine headaches, (17) depression, (18) acute myocarditis, (19) asthma, (20) maternal cytomegalovirus, (21) urolithiasis, (22) DVT prophylaxis, (23) ovarian dermoid tumors, (24) biliary atresia and/or cirrhosis, (25) first trimester adnexal mass, (25) hyditidiform mole or (26) ectopic pregnancy.

PRE-EXISTING CONDITIONS means a disease or physical condition of a Covered Person, not otherwise excluded by name or specific description on the date of the Person's loss, which existed prior to the Covered Person's effective date under the Group Policy. Any exclusion or limitation applies only to a disease or physical condition for which medical advice or treatment was received by the Covered Person during the 12 months prior to the effective date of coverage under the Group Policy. In no event will the exclusion or limitation apply to loss incurred after the earlier of:

1. The end of a continuous period of 12 months commencing on or after the effective date of the Covered Person's coverage during all of which the Person received no advice or treatment in connection with such disease or physical condition; or
2. The end of the 2-year period commencing on the effective date of the Covered Person's effective date of coverage under the Group Policy.

MEDICAL SERVICES

Anesthesia Administration is changed to read:

Anesthesia Administration - Reasonable and Customary Charges for the administration of anesthesia by an anesthesiologist to a Covered Person undergoing surgery while Hospital Confined or in a Same Day Surgery Facility. The anesthesiologist must be at the operation solely to provide the anesthesia service.

We will reduce benefits otherwise payable had an anesthesiologist administered anesthesia by [50%] if a nurse anesthetist, operating Doctor, or assistant Surgeon administers the anesthesia, including any incidental fluids, as part of a covered surgical procedure. When both an anesthesiologist and a nurse anesthetist bill for the same operative session, benefits will be limited to the Reasonable and Customary charges otherwise payable had the anesthesiologist been the sole provider of such services.

Coverage includes charges incurred for those for services performed in connection with dental procedures in a Hospital or Ambulatory Surgical Center when the Doctor treating the Covered Person certifies that, because of the patient's age or condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the procedures and the Covered Person is: (1) a child under 7 years of age who is determined by two dentists licensed in Arkansas to require, without delay, necessary dental treatment in a Hospital or Ambulatory Surgical Center for a significantly complex dental condition; (2) a person with a diagnosed serious mental of physical condition; or (3) a person with a significant behavioral problem as determined by the Covered Person's Doctor. This benefit does not apply to services performed in connection with temporomandibular joint disorders.

The following **MEDICAL SERVICES** are added**:**

ARKANSAS RESIDENT BENEFITS – The following benefits apply only when described services are provided to a Covered Person who is an Arkansas resident. Except as otherwise stated, they are subject to all the terms and conditions of the Group Policy.

Newborn Infants – When the Certificate evidences coverage for persons in addition to You, and You have given Us notice of a newborn as required by Automatic Coverage of Newborn and Adopted Children, coverage will include the Reasonable and Customary Charges incurred for the Medically Necessary care and treatment of a newborn child, while the child is Hospital Confined, as follows: (a) coverage for Sickness or Injury, congenital defects, and premature birth; (b) coverage for tests for hypthyroidism, phenylketonuria, galactosemia, sickle-cell amenia, and all other disorders of metabolism for which screening is performed by or for the State of Arkansas, as well as any testing of newborn infants hereafter mandated by law; and (c) a minimum of 48 hours up to 5 full days of routine nursery care and pediatric charges for a well newborn in a Hospital nursery or until the mother is discharged from the Hospital following the birth of the child, whichever is the lesser period of time.

Speech and Hearing - Reasonable and Customary Charges incurred for necessary care and treatment of loss or impairment of speech or hearing while Hospital Confined. Coverage does not include hearing instruments or devices.

Colorectal Screening - Reasonable and Customary Charges for colorectal cancer examinations and laboratory tests, while Hospital Confined or in an Ambulatory Surgical Center, for: (1) Covered Persons who are 50 years of age or older; (2) Covered Persons who are less than 50 years of age and at a high risk for colorectal cancer; (3) Covered Persons experiencing the following symptoms: bleeding from the rectum or blood in the stool; a change in bowel habits, such as diarrhea, constipation, or narrowing of the stool, that lasts more than 5 days.

The colorectal screening will involve an examination of the entire colon, including the following exams or laboratory tests, or both:

1. An annual fecal immunochemical test in conjunction with a flexible sigmoidoscopy every 5 years;
2. A double-contrast barium enema every 5 years; or
3. A colonoscopy every 10 years; and
4. Any additional medically recognized screening tests for colorectal cancer required by the Director of the Department of Health.

Follow-up screenings are covered as follows:

1. If the initial colonoscopy is normal, follow-up is recommended in 10 years;
2. For Covered Persons with 1 or more neoplastic plyps, adenomatous polyps, assuming that the initial colonoscopy was complete to the cecum and adequate preparation and removal of all visualized polyps follow-up is recommended in 3 years;
3. If single tubular adenoma of less than 1 centimeter (4 for patients with large sessile adenomas greater than 3 centimeters) especially if removed in piecemeal fashion, follow-up is recommended in 6 months or until complete polyp removal is verified by colonoscopy.

Diabetes – Reasonable and Customary Charges for equipment, supplies, medication and a one per lifetime self-management training and patient management, including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin-using diabetes, while Hospital Confined. The self-management diabetes training program must be Medically Necessary as determined by a Doctor. Additional training is covered when a Doctor prescribes the additional training as Medically Necessary because of a significant change in the Covered Person's symptoms or conditions.

EXCEPTIONS

Number 11 is revised to state as follows:

11. A Pre-Existing Condition as defined in the Group Policy, except as stated under DEFINITIONS and TIME LIMIT ON CERTAIN DEFENSES, PRE-EXISTING CONDITIONS.

AUTOMATIC COVERAGE OF NEWBORN AND ADOPTED CHILDREN is revised as follows:

Newborns: If the Group Policy provides coverage for Covered Persons other than You, the Policy will also provide coverage for newborn children when they live with You from the moment of birth. This coverage is free for the first 90 days.

Adopted Children: If the Group Policy provides coverage for Covered Persons other than You, the Policy will also provide coverage for adopted children and children who are placed for adoption from the date of the filing of a petition for adoption. This coverage for adopted children is free for the first 60 days of the filing of a petition for adoption if You apply for coverage within 60 days after the filing of the petition for adoption. However, the coverage will be free for the first 60 days from the moment of birth if the petition for adoption and application for coverage is filed within 60 days after the birth of the minor.

In order to continue coverage for a newborn or adopted child, You must do the following:

1. Send Us notice of the child within the 90 days after the date of the child's birth or before the premium due date, whichever is later (or, in the case of an adopted child, within the 60 days after the filing of the petition for adoption or birth of child); and
2. Send Us the additional premium for the child within 90 days of the child's date of birth or within 60 days of the date of petition for adoption or birth of the child.

As long as You pay the extra premium, the child will remain a Covered Person, subject to the Termination of Coverage and Loss of Coverage Eligibility provisions of the Group Policy. Coverage for a child that is placed with You for adoption will continue in accordance with the Termination of Coverage and Loss of Coverage Eligibility provisions, unless the placement is disrupted prior to legal adoption and the child is removed from placement.

We do not require an application for the child unless You have notified Us of the child later than the timeframe as required above.

TERMINATION OF COVERAGE

The following paragraph is added:

If coverage under the Group Policy ends and is replaced by a group health insurance plan issued by another insurer or self-funded health care plan, coverage under the Group Policy will continue for any Covered Person who is Hospital Confined on the date coverage under the Group Policy ends. Continuation of such benefits are subject to all terms and conditions the Group Policy, except those relating to termination of benefits. Such benefits will continue until the Hospital Confinement ends or until the maximum benefits available under the Group Policy are paid, whichever occurs first.

LOSS OF ELIGIBILITY

The last sentence in the first paragraph is revised as follows:

If a Covered Person's coverage ends under the Group Policy, in accordance with the paragraphs above, such Person may be eligible for Continuation or Conversion. Please see the Conversion Privilege and the State Continuation Privilege.

EXTENSION OF COVERAGE FOR SOME CHILDREN

The entire section is deleted and replaced with the following:

When an unmarried dependent child who is a Covered Person has reached the Limiting Age, coverage may continue if the child is, and remains, incapable of sustaining employment by reason of mental retardation or physical disability and who is chiefly dependent upon the Certificateholder for support and maintenance.

ANTEX may ask the Certificateholder to furnish proof of the incapacity or dependency. ANTEX will bear the cost of obtaining such proof. The Certificateholder is expected to notify ANTEX if the incapacity or dependency is removed or terminated in the future.

The premium rate for the handicapped dependent will remain at the child rate.

A section entitled TOTAL DISABILITY is added and states as follows:

TOTAL DISABILITY: "Total Disability" means a Covered Person's inability, because of Sickness or Injury, to perform the material and substantial duties of his/her occupation.

If a Covered Person suffers from Total Disability at the time of any termination or discontinuance of the Group Policy by ANTEX, regardless of the reason for the termination or discontinuance, ANTEX will provide an extension of benefits for a period of 12 months immediately following the date of termination or discontinuance. Benefits payable will be subject to the Group Policy's regular benefit limits.

CONVERSION PRIVILEGE

The first item number 1., is revised to state as follows:

1. A conversion policy is not available to a Covered Person if termination of his insurance under the Group Policy occurs:

a) Because he/she failed to make timely payment of any required premium; or

b) Because the Group Policy terminated and the insurance was replaced by similar coverage under another group policy within thirty-one (31) days of the date of termination; and

A section entitled STATE CONTINUATION PRIVILEGE is added and states as follows:

If coverage ends under the Group Policy for certain reasons, a Covered Person may be able to continue his coverage.

CONTINUATION:

A Covered Person may continue his coverage under the Group Policy and that of his dependents who are covered under the Group Policy if his coverage would otherwise end because of termination of membership or because of a change in marital status. Such coverage will be continued if the person:

1. Has been continuously covered under the Group Policy for the 3 month period prior to termination of membership or change in marital status; and

2. Is not eligible for Medicare or is not fully covered (i.e., all Pre-Existing Conditions are covered) under any other group medical policy or contract;

Continuation will be allowed under this provision until all Pre-Existing Conditions are covered or would be covered under another group policy or contract or until termination pursuant to this continuation provision or pursuant to any applicable provision of federal law.

To continue coverage, the person must request continuation in writing within 10 working days of termination of membership or change in marital status. Premiums must be p[aid on a monthly basis in advance in accordance with the terms of the Group Policy.

This continuation will end on the earliest of the following dates:
1. 120 days from the date continuation began;
2. The end of the period for which premiums are paid on a timely basis;
3. The premium due date following the date the person becomes eligible for Medicare;
4. The date maximum benefits available under the Group Policy are paid for such person; or
5. The date of termination of the Group Policy; however, continuation will continue under any replacement policy.

Upon termination of this continuation, the person may have the right of conversion described above. Any person who elects the conversion privilege waives the right to this continuation.

GENERAL PROVISIONS

Under **TIME LIMIT ON CERTAIN DEFENSES,** the following is changed to read:

2. <u>PRE-EXISTING CONDITIONS</u>:
No claim for loss incurred after the earlier of: (a) the end of a continuous period of 12 months commencing on or after the Covered Person's effective date of coverage under the Group Policy, during which the Covered Person has received no medical advice or treatment in connection with such disease or physical condition or (b) the end of the 2-year period commencing on the effective date of the Covered Person's coverage under the Group Policy will be reduced or denied unless:

(a) The disease or physical condition has been excluded from coverage by name or specific description, and;
(b) Such exclusion is in effect on the date the loss is incurred.

TIME FOR PAYMENT OF CLAIMS is changed to read:

TIME FOR PAYMENT OF CLAIMS: We will pay or deny each Clean Claim as follows: (1) if the claim is filed electronically, within 30 days after the date We receive the claim; or (2) if the claim is filed on paper, within 45 days after the date we receive the claim. We will notify the claimant of any deficiencies in the claim not less than 30 days after the date We receive the claim. The notice will give an explanation of any additional information required. We will suspend the claim until We receive the requested information. We will reopen and pay or deny the suspended claim within 30 days after We receive the information requested..

If We fail to pay or deny a Clean Claim or to give notice that We need more information to pay a claim, We will pay the claimant for the period beginning on the 61st day after receipt of the Clean Claim and ending on the Clean Claim payment date (this is called the delinquent payment period), calculated as follows: the amount of the Clean Claim payment times 12% per annum times the number of days in the delinquent payment period, divided by 365. We will pay this penalty without any action by the claimant.

A "Clean Claim" means a claim for payment of health care expenses that is submitted on a HCFA 1500 on a UB92 in a format required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), or on Our standard claim form with all required fields completed in accordance with Our published claim filing requirements. A Clean Claim does not include a claim (1) for payment of expenses incurred during a period of time for which premiums are delinquent; or (2) for which We need additional information in order to resolve the claim.

The following is added:

NOTICE TO CERTIFICATEHOLDERS: We are here to serve the Certificateholder. As our Certificateholder, Your satisfaction is very important to Us. If You have a question about Your Certificate, if You need assistance with a problem, or if You have a claim, You should first contact Your insurance agent or Us at 1-800-899-6520. If You do not have Your agent's name, address, or phone number, please contact Us and We will be able to supply the information.

If We at ANTEX fail to provide You with reasonable and adequate service, You should feel free to contact:

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, AR 72201-1904
1-800-852-5494

EXTERNAL REVIEW PROCEDURE – In certain cases, the Certificateholder has the right to request an External Review Procedure, as described in this Section.

The following terms are defined:

Adverse Determination means the Company's determination that an admission, availability of care, continued stay or other Medical Service has been reviewed and, based upon the information provided, the requested payment for the service is denied, reduced or terminated, because:

(a) The requested Health Care service does not meet the Company's requirements for Medical Necessity, or
(b) The requested Health Care service has been found to be "Experimental/Investigational."

In order to qualify as an "Adverse Determination:"

(a) The Adverse Determination must be a Final Adverse Determination, except as may be provided herein.
(b) The Adverse Determination must involve treatment, services, equipment, supplies, or drugs that would require the health benefit plan to expend five hundred dollars ($500) or more of expenditures.

Adverse Determination does not include the Company's determination to deny a Health Care service based upon:

(a) An express exclusion in the health benefit plan other than a general exclusion for "Medical Necessity" or "Experimental/Investigational;"
(b) An express limitation in the health benefit plan with respect to the number of visits, treatments, supplies or services for a covered benefit in a given calendar period or over the lifetime of the Covered Person;
(c) An express limitation in the health benefit plan with respect to a maximum dollar limitation with respect to a covered benefit in a given calendar period or over the lifetime of the Covered Person;
(d) The Company's determination that an individual is not eligible to be a Covered Person;
(e) The Company's determination that treatment, service, or supplies were requested or obtained by a Covered Person through fraud or material misrepresentation.
(f) The health benefit plan's procedure for determining the Covered Person's access to a Health Care Provider, including but not limited to a network access provision;
(g) Illegality of services or the means or methods of administering them;
(h) FDA or other government agency determinations, reports or statements; or
(i) Licensure, permit or accreditation status of a Health Care Provider.

Authorized Representative means:

(a) A person to whom a Covered Person has given express written consent to represent the Covered Person in an External Review;
(b) A person authorized by law to provide substituted consent for a Covered Person; or
(c) When the Covered Person is unable to provide consent, a family member of the Covered Person or the Covered Person's treating Health Care Professional if a family member is unavailable.

Commissioner means the Arkansas Insurance Commissioner.

Covered Benefits or Benefits means those Health Care services to which a Covered Person is entitled under the terms of a health benefit plan.

Covered Person means You. Covered Person shall also mean the Covered Person's Authorized Representative, as defined in this regulation.

Disclose means to release, transfer or otherwise divulge protected Health Information to any person other than the individual who is the subject of the protected Health Information.

Emergency Medical Condition means medical conditions of a recent onset and severity, including, but not limited to, severe pain that would lead a prudent lay person, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

Emergency Services means Health Care items and services furnished or required to evaluate and treat an Emergency Medical Condition.

External Review means a process, independent of all affected parties, to determine if a Health Care service is medically necessary or experimental/ investigational.

Facility means an institution providing Health Care services or a Health Care setting, including but not limited to, hospitals and other licensed inpatient centers, outpatient surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

Final Adverse Determination means an Adverse Determination involving a covered benefit that has been upheld by a health carrier at the completion of the health carrier's internal grievance procedure or Utilization Review procedure. If the health carrier does not have, nor is required by law to have, an internal grievance procedure or Utilization Review procedure, an Adverse Determination shall be considered a Final Adverse Determination.

Health care professional means a physician or other Health Care practitioner licensed, accredited or certified to perform specified health services consistent with state law.

Health Care Provider or Provider means a Health Care Professional or a Facility.

Health Care Services means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.

Health Information means information or data, whether oral or recorded in any form or medium, and personal facts or information about events or relationships that relates to:

(a) The past, present or future physical, mental, or behavioral health or condition of an individual or a member of the individual's family;

(b) The provision of Health Care services to an individual; or

(c) Payment for the provision of Health Care services to an individual.

Independent Review Organization means an entity that conducts independent External Reviews of Adverse Determinations and Final Adverse Determinations.

Medical or Scientific Evidence means the following sources:

(a) Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;
(b) Peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the National Institutes of Health's Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline and MEDLARS database Health Services Technology Assessment Research (HSTAR);
(c) Medical journals recognized by the Secretary of Health and Human Services under Section 1861(t)(2) of the federal Social Security Regulation;
(d) The following standard reference compendia: The American Hospital Formulary Service-Drug; The American Dental Association Accepted Dental Therapeutics; and The United States Pharmacopoeia-Drug Information;

(e) Findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including: The federal Agency for Healthcare Research and Quality; The National Institutes of Health; The National Cancer Institute; The National Academy of Sciences; The Centers for Medicare and Medicaid Services; Any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of Health Care services; and Any other Medical or Scientific Evidence that is comparable to the sources listed in Subparagraphs (a) through (e).

Medical or Scientific Evidence shall not include published peer-reviewed literature sponsored to a significant extent by a pharmaceutical manufacturing company or medical device manufacturer.

Medically Necessary or Medical Necessity has the same definition as found under the section of the Certificate titled **DEFINITIONS.**

Person means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, a limited liability company, any similar entity or any combination of the foregoing.

Protected Health Information means Health Information that is not subject to disclosure under state and/or federal law.

Retrospective Review means a review of Medical Necessity conducted after services have been provided to a patient, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication for payment.

Utilization Review and Utilization Review Procedure mean the system for reviewing the appropriate and efficient allocation of hospital resources and medical services given or proposed to be given to a patient or group of patients.

Requesting an External Review, General Information - At the time of an Adverse Determination or a Final Adverse Determination, the Company will notify the Covered Person and Health Care Professional in writing of the right to request an External Review.

Before filing a request for an External Review, a Covered Person must exhaust the Company's internal grievance procedures (unless the Company waives this requirement). A Covered Person has exhausted the internal grievance procedure when:

(a) The Covered Person has filed an appeal regarding an Adverse Determination with the Company; and
(b) The Covered Person has not received a written decision on the appeal from the Company within 30 days following the date the Covered Person filed the appeal. (This 30 day requirement does not apply if the Covered Person requested or agreed to a delay of the 30 day requirement); or
(c) The Covered Person has received a written decision regarding the appeal and the Company has made a Final Adverse Determination.

Once the Covered Person has received a Final Adverse Determination, the Covered Person has 60 days to request of External Review. The Covered Person must request an External Review in writing.

When requesting an External Review, the Covered Person will be required to authorize the release of any medical records that may be required for review in making the decision on the External Review. the Company will attach the authorization form to the External Review Notice.

A Covered Person has the right to contact the Commissioner for assistance with the External Review process at any time. The Commissioner's contact information is:

Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201
(501)371-2600 or 1-800-282-9134
insurance.Consumers@Arkansas.gov

Standard External Review – When the Company receives a request for an External Review, it will assign an Independent Review Organization (IRO) to the External Review.

The IRO will conduct a preliminary review to determine if:

(1) The request meets External Review requirements;

(2) The Covered Person has exhausted the Company's internal grievance process (unless the Covered Person is not required to exhaust the grievance process as described in this notice); and
(3) The Covered Person has provided all information and forms required to process an External Review, including the authorization form that the Company provided at the time of the Adverse or Final Adverse determination.

Within 5 business days, the IRO will review the Request and notify the Covered Person whether the request is complete and whether the IRO has accepted the Request. Within 7 business days after the date of receipt of this IRO notice, the Company will provide to the IRO, the Covered Person, and the Covered Person's treating Health Care Professional the documents and any information considered in making the Adverse Determination or Final Adverse Determination, together with any additional information required.

The IRO notice will include a statement that the Company, the Covered Person and the Covered Person's treating Health Care Professional may submit additional information and supporting documentation in writing to the IRO within 7 business days following the date of receipt of the notice. The IRO will consider this information when conducting the External Review. The IRO shall review all of the information and documents received in writing by the Covered Person, the Covered Person's treating Health Care Professional, and the Company.

If the request is not complete, the assigned IRO will, within 5 business days, inform the Company, the Covered Person, and the Covered Person's treating Health Care Professional what information or materials are needed to make the request complete. The IRO will immediately forward copies of any additional information to the Company.

If the request is not accepted for External Review, the assigned IRO will inform the Covered Person, the Covered Person's treating Health Care Professional and the Company in writing within 5 business days of the reasons for its nonacceptance.

In reaching a decision to accept or reject a matter for External Review, the IRO is not bound by any decisions or conclusions reached during the Company's internal grievance procedure or Utilization Review procedure.

Except in the case of the IRO terminating and reversing the Company's Adverse Determination or Final Adverse Determination because the Company failed to provide documents and information to the IRO within an acceptable time frame, failure by the Company or its Utilization Review organization to provide the documents and information within the time frame required will not delay the conduct of the External Review.

If the Company or its Utilization Review Organization fails to provide the documents and information within the time frame required, the IRO may terminate the External Review and make a decision to reverse the Adverse Determination or Final Adverse Determination.

Upon receipt of the information, if any, required to be forwarded to the IRO, the Company may reconsider its Adverse Determination or Final Adverse Determination that is the subject of the External Review.

Reconsideration by the Company of its Adverse Determination or Final Adverse Determination will not delay or terminate the External Review.

The External Review may only be terminated if the Company decides, upon completion of its reconsideration, to reverse its Adverse Determination or Final Adverse Determination and provide coverage or payment for the Health Care service that is the subject of the Adverse Determination or Final Adverse Determination.

Immediately upon making the decision to reverse its Adverse Determination or Final Adverse Determination, the Company shall notify the Covered Person, the Covered Person's treating Health Care Professional, and the IRO in writing of its decision.

The IRO will terminate the External Review upon receipt of the notice from the Company regarding its reversal.

In addition to the documents and information referred to above, the IRO, to the extent the information or documents are available and the IRO considers them appropriate, shall consider the following in reaching a decision:

(1) The Covered Person's medical records;

(2) The treating Health Care Professional's recommendation;
(3) Consulting reports from appropriate Health Care Professionals and other documents submitted by the health carrier, Covered Person, or the Covered Person's treating Health Care Professional;
(4) The most appropriate practice guidelines, which may include generally accepted practice guidelines, evidence-based practice guidelines or any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;
(5) Any applicable written screening procedures, decision abstracts, clinical protocols and practice guidelines used by a health carrier to determine the necessity and appropriateness of Health Care services;
(6) If the Adverse Determination involves a denial of coverage based on a determination that the recommended or requested Health Care services is "experimental" or "investigational," the IRO shall also consider whether:
   (a) The recommended or requested Health Care service or treatment has been approved by the federal Food and Drug Administration for the condition, while realizing that treatments or services are often legitimately used for purposes other than those listed in the FDA approval; or
   (b) Medical or scientific evidence demonstrates that the expected Benefits of the recommended or requested Health Care service or treatment is more likely than not to be more beneficial to the Covered Person than any available standard Health Care service or treatment and the adverse risks of the recommended or requested Health Care service or treatment would not be substantially increased over those of available standard Health Care services or treatments.

Within 45 calendar days after the date of receipt of the request for an External Review, the IRO shall provide written notice of its decision to uphold or reverse the Adverse Determination or the Final Adverse Determination to the Covered Person, the Covered Person's treating Health Care Professional, and the Company.

The IRO notice will include:
(a) A general description of the reason for the request for External Review;
(b) The date the IRO received the assignment from the health carrier to conduct the preliminary review of the External Review request;
(c) The date the External Review was conducted, if appropriate;
(d) The date of its decision;
(e) The principal reason or reasons for its decision;
(f) The rationale for its decision; and
(g) References to the evidence or documentation, including the practice guidelines, considered in reaching its decision.

If the Adverse Determination involves a denial of coverage based on a determination that the recommended or requested Health Care services is "experimental" or "investigational," the IRO shall also consider whether:

(i) A description of the indicators relevant to determining whether there is sufficient evidence to demonstrate that the recommended or requested Health Care service or treatment is more likely than not to be more beneficial to the Covered Person than any available standard Health Care services or treatments and the adverse risks of the recommended or requested Health Care service or treatment would not be substantially increased over those of available standard Health Care services or treatments; and

(ii) A description and analysis of any Medical or Scientific Evidence considered in reaching the opinion.

Upon receipt of a notice of a decision reversing the Adverse Determination or Final Adverse Determination, the Company will immediately approve the coverage that was the subject of the Adverse Determination or Final Adverse Determination.

The assignment by the Company of an approved IRO to conduct an External Review in accordance with this section shall be fair and impartial. the Company and the IRO shall comply with standards approved by the Commissioner to ensure fairness and impartiality in the assignment by health carriers of approved IRO to conduct External Reviews.

Expedited External Review – A Covered Person may make a request for an Expedited External Review at the time the Covered Person receives an Adverse Determination or a Final Adverse Determination.

The Covered Person may request an expedited External Review of an Adverse Determination if:

(a) The Covered Person has a medical condition where the timeframe for completion of an expedited review of an appeal set forth in the Company's internal grievance procedure or Utilization Review procedure would seriously jeopardize the life or health of the Covered Person or would jeopardize the Covered Person's ability to regain maximum function; or
(b) The Adverse Determination involves a denial of coverage based on a determination that the recommended or requested Health Care service or treatment is "experimental" or "investigational," and the Covered Person's treating physician certifies in writing that the recommended or requested Health Care service or treatment would be significantly less effective if not promptly initiated.

Note: A Covered Person may file a request for an expedited External Review at the same time the Covered Person files a request for an expedited review of an appeal under the Company's grievance or utilization review procedure if:

(a). The Covered Person has a medical condition where the timeframe for completion of an expedited review of an appeal set forth in the Company's internal grievance procedure or utilization review procedure would seriously jeopardize the life or health of the Covered Person or would jeopardize the Covered Person's ability to regain maximum function; or
(b). The Adverse Determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is "experimental" or "investigational," and the Covered Person's treating physician certifies in writing that the recommended or requested health care service or treatment would be significantly less effective if not promptly initiated.

The IRO will determine whether the Covered Person shall be required to complete the Company's expedited internal grievance procedure or Utilization Review procedure before it conducts the expedited External Review. Upon a determination that the Covered Person must first complete the expedited internal grievance review procedure or Utilization Review procedure, the IRO immediately shall notify the Covered Person and the Covered Person's treating Health Care Professional of this determination and that it will not proceed with the expedited External Review until the expedited internal grievance procedure or Utilization Review procedure is completed and the Adverse Determination or Final Adverse Determination is upheld.

The Covered Person may request an expedited External Review of a Final Adverse Determination if:

(a) The Covered Person has a medical condition where the timeframe for completion of a standard External Review would seriously jeopardize the life or health of the Covered Person, or would jeopardize the Covered Person's ability to regain maximum function; or
(b) The Final Adverse Determination concerns:

(i) An admission, availability of care, continued stay or Health Care service for which the Covered Person received Emergency Services, but has not been discharged from a Facility; or

(ii) A denial of coverage based on a determination that the recommended or requested Health Care service or treatment is experimental or investigational, and the Covered Person's treating physician certifies in writing that the recommended or requested Health Care service or treatment that is the subject of the request would be significantly less effective if not promptly initiated.

At the time the Covered Person makes a request for an expedited External Review, the Covered Person or the Covered Person's treating Health Care Professional shall submit additional information and supporting documentation that the IRO will consider when conducting the expedited External Review.

At the time the Company receives a request for an expedited External Review, the Company will immediately assign an IRO to the case.

At the time the Company assigns an IRO to conduct the expedited External Review, the Company shall immediately provide or transmit all documents and information considered in making the Adverse Determination or Final Adverse Determination, as well as any additional information and supporting documentation, to the IRO, the Covered Person, and the Covered Person's treating Health Care Professional via electronically, facsimile or any other available expeditious method.

The IRO will, as expeditiously as the Covered Person's medical condition or circumstances require, but in no event more than 72 hours after the date of receipt of the request for an acceptable expedited External Review:

(a) Make a decision to uphold or reverse the Adverse Determination or Final Adverse Determination; and
(b) Notify the Covered Person, the Covered Person's treating Health Care Professional, and the Company of the decision.

If the notice from the IRO was not in writing, within 2 days after the date of providing that notice, the IRO shall:

(a) Provide a written or electronic media confirmation of the decision to the Covered Person and the Company; and
(b) Include the information required for a Standard External Review Notice.

In reaching a decision, the IRO is not bound by any decisions or conclusions reached during the health carrier's Utilization Review process or the Company's internal grievance process.

Upon receipt of notice of a decision reversing the Adverse Determination or Final Adverse Determination, the Company will immediately approve the coverage that was the subject of the Adverse Determination or Final Adverse Determination.

An expedited External Review may not be provided for adverse or Final Adverse Determinations involving a Retrospective Review.

Binding Nature of External Review Decision -

(a) An External Review decision is binding on the Company except to the extent the Company has other remedies available under applicable federal or state law.

(b) An External Review decision is binding on the Covered Person except to the extent the Covered Person has other remedies available under applicable federal or state law.

(c) A Covered Person may not file a subsequent request for External Review involving the same Adverse Determination or Final Adverse Determination for which the Covered Person has already received an External Review decision pursuant to this regulation.

Filing Fees –

(a) Except in the case of a request for an expedited External Review, at the time of filing a request for External Review, the Covered Person shall submit to the IRO a filing fee of $25 along with the information and documentation to be used by the IRO in conducting the External Review.

(b) Upon application by the Covered Person, the Commissioner may waive the filing fee upon a showing of undue financial hardship.

(c) The filing fee shall be refunded to the person who paid the fee if the External Review results in the reversal, in whole or in part, of the Company's Adverse Determination or Final Adverse Determination that was the subject of the External Review.

(d) the Company against which a request for a standard External Review or an expedited External Review is filed shall pay the cost of the IRO for conducting the External Review.

This Amendment is signed on behalf of the Company.

Secretary

Enrollment Application to
American National Life Insurance Company of Texas (ANTEX) • Administrative Office • Galveston,Texas

Print in Black ❑ **New** ❑ **Reinstatement-Existing #** _____ ❑ **Change-Existing #** _____

1. Special Requests: Mail Certificate to Applicant: ❑ Yes ❑ No Requested Effective Date: _____

I, as a member of the association, apply for:

2. ❑ **Catastrophic Hospital Plan:**

❑ **Option A**
Deductible Amount:
❑ $750 ❑ $1,500 ❑ $2,000 ❑ $2,500 ❑ $5,000
❑ $10,000 ❑ $15,000 ❑ $20,000 ❑ $25,000

PPO Rider ❑ Yes ❑ No
PPO Selected _____

❑ **Option B** (Family Coverage only)
Deductible Amount:
❑ $3,000 ❑ $4,000 ❑ $5,000
❑ $10,000

Rate of Payment:
❑ 100% ❑ 80% ❑ 50%
Stop-Loss Amount: (Option A only)
❑ $5,000 ❑ $10,000
Per Injury/Sickness Maximum
❑ $2,000,000

Optional Benefits: *(NON-HSA ONLY)*

Accident Rider:

Max. Amount	Deductible
❑ $500	❑ $100
❑ $1,000	❑ $250
❑ $1,500	❑ $250
❑ $2,500	❑ $500

Childbirth Rider
❑ $1,000 ❑ $2,000

OP Diagnostic Testing Rider: ❑ Yes* ❑ No
Deductible Amount:: ❑ $750 ❑ $1,000 ❑ $1,500

OP Drug Rider: ❑ Yes ❑ No
❑ $500 ❑ $1,000 (Individual Deductible)
❑ $1,000 ❑ $2,000 (Family Deductible)

OP Doctor Rider: ❑ Yes** ❑ No
Deductible Amount: ❑ $750 ❑ $1,000 ❑ $1,500
❑ $2,000 ❑ $2,500 ❑ $3,000
(❑ $4,000 ❑ $5,000 only available with the $100,000 Maximum Benefit)
Maximum Benefit: ❑ $25,000 ❑ $100,000

*(Not available when OP Doctor Rider selected) **(Not available when OP Diagnostic Testing Rider selected)

❑ **HSA Plan:**

Plan Deductible Amount:
Individual: ❑ $1,500 ❑ $2,000
❑ $2,500 ❑ $5,000
Family: ❑ $3,000 ❑ $4,000 ❑ $5,000
❑ $10,000(100% Rate of Pmt.)

Rate of Payment:
❑ 100% ❑ 80% ❑ 50%
Per Injury/Sickness Maximum
❑ $2,000,000

PPO Rider ❑ Yes ❑ No
PPO Selected _____

3. Initial Modal Premium: Amount: $ _____

TO BE COMPLETED PERSONALLY BY THE APPLICANT AND SPOUSE, IF APPLYING.

4. Proposed Insured Information

Proposed Insured(s) (Print Last Name, First Name, MI.)	Relationship	Marital Status Single	Marital Status Married	Sex	Age	Date of Birth Mo.	Date of Birth Day	Date of Birth Year	Place of Birth	Build Height	Build Weight	Social Security Number
1	Applicant	☐	☐									
2	Spouse	☐	☐									
3												
4												
5												
6												

5. Address (Permanent U.S. residence of primary insured.)

Number and Street or R.F.D.

City State Zip

Best time to call:
Phone: Hm ( ) _____ ❑ A.M. ❑ P.M.
Work: ( ) _____ ❑ A.M. ❑ P.M.
Cell: ( ) _____ ❑ A.M. ❑ P.M.

E-Mail Address: _____

6. Employment Data	Employed Full-Time?	Name of Employer *(if self employed, describe duties)*	Duties/Title	Avg. Monthly Earnings Last 12 Months
Applicant	☐Yes ☐No			$
Spouse	☐Yes ☐No			$

THE HEALTH INSURANCE COVERAGE THE AGENT HAS JUST DESCRIBED TO YOU IS NOT DESIGNED NOR INTENDED AS A HEALTH INSURANCE PLAN TO BE PROVIDED BY AN EMPLOYER FOR EMPLOYEES.

CHANGES IN STATUS INDICATED BELOW MAY AFFECT FUTURE ELIGIBILITY FOR INSURANCE COVERAGE.
ALL OF THE FOLLOWING QUESTIONS MUST BE ANSWERED:

1. Is the Applicant or Spouse the owner of an incorporated business?	❑ Yes	❑ No
2. Is the Applicant or Spouse a sole proprietor or a partner in a partnership?	❑ Yes	❑ No
3. Is the Applicant or Spouse an employee of a business?	❑ Yes	❑ No
a Will the Applicant's or Spouse's employer pay a portion of your health insurance premium?	❑ Yes	❑ No
b Will the Applicant or Spouse be reimbursed by employer, through wage adjustments or otherwise, for any portion of the premium?	❑ Yes	❑ No
c. Will the Applicant's or Spouse's health insurance plan be treated by you or your employer as part of a plan or program for the purposes of Section 106, 125 or 162, Internal Revenue Code of 1986 (26 U.S.C. Section 106, 125 or 162)?	❑ Yes	❑ No

7. Is any Proposed Insured or household member (including students away at school, whether or not now applying for coverage) currently pregnant?
❑ Yes ❑ No (If "Yes", this coverage cannot be provided.)_____

8. Has any Proposed Insured used any type of tobacco (including cigarettes, cigars, and/or smokeless tobacco) during the past 12 months?
❑ Yes ❑ No (If "Yes", state whom, and details.)_____

9. Are all Proposed Insureds legal citizens of the United States? ❑ Yes ❑ No
If "No", is such Proposed Insured a permanent resident? ❑ Yes ❑ No (If "No", this coverage cannot be provided).

10. Does any Proposed Insured intend to travel or reside outside the U.S.A.? ❑ Yes ❑ No
If "Yes", give details_____

11. Are all your dependent children under the age of 26? ❑ Yes ❑ No
(Do not include on this application any of your children who are 26 years of age or older or any married children).

12. Has any Proposed Insured applying been covered under a health insurance plan including COBRA within the last 18 months? ❑ Yes ❑ No.
a. Will requested coverage replace or change any existing medical insurance? ❑ Yes ❑ No
b. If Yes, give plan details below and provide reason for replacement such as carrier terminated coverage or lower rates, etc.
c. **You should not cancel your existing medical insurance coverage until you receive written notification of acceptance from ANTEX.** If accepted, do you agree to discontinue your current medical insurance? ❑ Yes ❑ No

Question#	Name of Company & Policy #	Plan Type Grp. or Ind.	Medical Insurance	Reason For Termination	Effective Date Month-Year	Termination Date Month-Year

13. Is any Proposed Insured applying for coverage under the federal HIPAA Program? ❑ Yes ❑ No If "Yes", please submit a letter of Creditable Coverage with the Enrollment Application.

14. Has any Proposed Insured applied for life, accident or health insurance or for reinstatement of such insurance which was restricted or rated up?
❑ Yes ❑ No (If "Yes", give details)_____

15. Has any Proposed Insured made claim or received benefits for any injury or sickness in the last 12 months; or are they presently receiving any government aid such as Medicaid, Medicare, or SSDI? ❑ Yes ❑ No (If "Yes", state whom, name of insurer, month, year, and nature of ailment.)

16. Has any Proposed Insured ever taken part in: skydiving, hang gliding, parachuting, bungee jumping, rock or mountain climbing, scuba diving, racing (any type), motorcycle riding, professional sports, piloting an aircraft, or rodeo events? ❑ Yes ❑ No (If "Yes", indicate activity and give details.)

17. Has any Proposed Insured had a driver's license suspended, any traffic violations, DWI/DUI/OUI's or been arrested within the past 2 years?
❑ Yes ❑ No (If "Yes", give details and provide Driver's License # and state of issue)_____

18. Please list name and address of family/Primary Care Physician(s), reason and date last seen for **each** Proposed Insured:

Proposed Insured	Condition, injury symptoms, diagnosis & treatment	Onset Date Month/Year	Date of last treatment	Results/Degree of recovery	Physician Name/Address

THE FOLLOWING QUESTIONS ARE TO BE ANSWERED FOR EACH PERSON APPLYING FOR COVERAGE.
ANY MISSTATEMENTS MAY AFFECT YOUR COVERAGE — GIVE FULL DETAILS TO ALL "YES" ANSWERS IN THE SPACE PROVIDED.

19. Within the last 10 years, has any Proposed Insured had any indication of, diagnosis of, or treatment for:

	Yes	No
a. A respiratory or lung disorder, for example, allergies, sinusitis, reactive airway disease, asthma, bronchitis, tuberculosis, pneumonia, or emphysema;	❑	❑
b. A circulatory or heart disorder, for example, high blood pressure, high cholesterol, heart attack, heart valve disorder, murmur angioplasty/bypass, chest pain, irregular heart rhythm, varicose veins, phlebitis or stroke;	❑	❑
c. An immune, blood or spleen disorder, for example, anemia, leukemia, lymphoma, connective tissue disease, lupus, scleroderma, or clotting disorder;	❑	❑
d. A digestive or gastrointestinal disorder, for example, ulcer, gastritis, reflux disorder, hepatitis, Crohn's Disease, ulcerative colitis, cirrhosis, irritable bowel, hemorrhoids, hernia or any disorder of the pancreas, liver, rectum or gallbladder;	❑	❑
e. A nervous disorder, seizures, tremors, headaches, paralysis, palsy or injury of the brain, spinal cord, or nerves;	❑	❑
f. A mental disorder, for example, emotional problems, eating disorder, attention deficit disorder, anxiety, depression, autism, sleep disorder, or received psychiatric treatment or counseling;	❑	❑
g. An endocrine disorder, for example, diabetes mellitus or insipidus, low or high blood sugar, disorder of the thyroid, parathyroid, pituitary, or adrenal glands;	❑	❑
h. A urinary tract disorder, for example, urinary tract stone, bladder or kidney infections, renal reflux, incontinence, or blood in the urine;	❑	❑
i. A muscular or skeletal disorder, for example, arthritis, gout, fibromyalgia, bone, joint, muscle, back, spine disorder, disc disease, sciatica, or received chiropractic treatment or acupuncture;	❑	❑
j. A facial bone or jaw disorder, for example, birth defect, congenital anomaly, malformation, temporomandibular joint disorder(TMJ), physical deformity, cleft palate or lip;	❑	❑
k. Cancer in any form, tumor, cyst, polyp, or growth of any kind;	❑	❑
l. An eye, ear, nose, throat disorder, for example, glaucoma, cataracts, ear infections, ear tubes, hearing impairment, enlarged tonsils/adenoids, vertigo, sleep apnea or deviated nasal septum;	❑	❑
m. A skin or subcutaneous tissue disorder, for example, burns, scars or hemangioma;	❑	❑
n. Mental or physical impairment or deformity; or congenital abnormality, mental retardation, developmental delay; or trait not previously disclosed;	❑	❑
o. **For Male Proposed Insured Only**... A male reporductive disorder, for example, disorder of the prostate, testicles, elevated PSA, or a sexually transmitted disease;	❑	❑
p. **For Female Proposed Insureds (18+) Only...** i. Any disorder or condition of the female reproductive organs, for example, abnormal Pap Smear, irregular or excessive menstruation, endometriosis, infertility, pregnancy complications including Cesarean section delivery, cystocele, rectocele, pelvic relaxation, dysmenorrhea, chronic pelvic pain, or a sexually transmitted disease, or HPV (human papilloma virus);	❑	❑
ii. Date of last Pap Smear _____ Results _____		
iii. Had instructions to have a repeat Pap Smear or any follow-up treatment or tests as a result of your last Pap Smear; or...	❑	❑
iv. A breast disorder, disease, changes, or condition, lump(s) aspiration(s), calcifications, biopsies, removal or placement of breast implants, or mammoplasty?	❑	❑
20. Does any Proposed Insured have a prosthetic device present, for example, plates, screws, pins rods, implants, shunts, pacemakers, valve replacements or stents or fixation devices?	❑	❑
21. Within the past 5 years, has any Proposed Insured: **a**. Been hospital confined, had surgery or discussed surgery, medical treatment or testing including cosmetic or reconstructive surgery with a doctor not otherwise listed on this application?	❑	❑
b. Had an EKG, chest x-ray, blood study, contacted or seen a physician, psychologist, chiropractor, counselor, therapist, or any other person providing health care services not otherwise listed on this application?	❑	❑
22. Within the past 12 months, has any Proposed Insured experienced or been treated by a physician for a change in weight of more than 12 pounds?	❑	❑
23. Has any Proposed Insured ever been: a. Treated or counseled for alcohol or drug use, or attended a drug or alcohol support group; or...	❑	❑
b. Advised by a physician to seek treatment or discontinue or decrease alcohol or drug consumption; or...	❑	❑
c. Under the influence of marijuana, narcotics, barbiturates, amphetamines, hallucinogens, or used any other drugs not prescribed by a physician?	❑	❑
24. Within the last six months, has any Proposed Insured taken any prescription medication or are now taking any prescription medication or receiving treatment of any kind for any condition not listed in any of the previous questions?	❑	❑
25. Within the last 10 years, has any Proposed Insured ever received a positive diagnosis or been treated for HIV, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	❑	❑

COMPLETE THE FOLLOWING FOR EACH "YES" ANSWER TO QUESTIONS 19 THROUGH 25 ABOVE.

Question Number	Proposed Insured	Date of Treatment From	Date of Treatment To	Reason for Check-up, Diagnosis, Illness or Condition, Frequency of Attacks	Treatment or Findings, Medication, Recommendations, Hospitalization and/or Surgery, Degree of Recovery	Name and Address of Each Physician, Practitioner and Medical Facility

If additional space is needed, please use the separate sheet provided, sign, date and return with the Enrollment Application.

APPLICATION DECLARATION & AGREEMENTS

I have personally completed this Enrollment Application and represent that all the answers and statements on this Enrollment Application are true, complete, and correctly recorded and agree they will be used to determine the eligibility for coverage applied for, for each Proposed Insured. I understand and agree that: 1) all statements and answers in this Enrollment Application, including any supplements, are complete and true; 2) I have personal knowledge of the medical history of each Proposed Insured; 3) any incorrect or incomplete information in this Enrollment Application may result in loss of coverage or claim denial; 4) no insurance coverage shall take effect unless the coverage applied for becomes effective or requested change is approved by ANTEX and the Certificate or requested change is delivered to the Applicant, and the first full premium paid during the lifetime and good health of all Proposed Insureds. I will notify and provide the Company with any evidence required by it to determine my future eligibility for coverage under the Group Policy. I acknowledge that I have received and read the material describing the rights of the Eligible Individual under the HIPAA mandate and understand its content.

Insurance Fraud: - Warning: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

I further understand and agree that:

1. A future change in my employment status may cause me to no longer be eligible for coverage under the Group Policy; and
2. Eligibility for coverage under the Group Policy does not constitute initial coverage under the Group Policy; and
3. Coverage under the Group Policy is subject to ANTEX's underwriting criteria.

Attention Applicant And Spouse:
After this Enrollment Application has been completed, and before you sign it, read it carefully to be certain that all information has been properly recorded.
I agree that my electronic signature on this Enrollment Application serves as my original signature.

Signed at _____ Date _____
City State Zip

Applicant's Signature _____ Spouse's Signature _____

Agent Name _____ Code/Writing# _____

Fax# _____ Email _____

AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE MEDICAL INFORMATION

I hereby authorize any physician, medical practitioner, hospital, clinic or other medically related facility, insurance company, insurance support organization, business partner, pharmacy, government agency, group policy holder, employer, benefit plan administrator, MIB, Inc., the Department of Motor Vehicle Registration, and paramedical facility to provide to AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS, or to any agent, attorney, consumer reporting agency, or an independent administrator, including medical record retrieval services, pharmaceutical services, acting on behalf of AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS or its reinsurers behalf, information concerning advice, care or treatment sought by or provided to me and/or any other applicant for coverage, including information relating to medical history, medical conditions, treatment, hospitalizations or confinements, ailments, and/or drug, alcohol or tobacco usage of the Proposed Insured(s). It is understood that AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS underwriters, claims examiners, reinsurers, attorneys or the medical director may disclose such health information to the aforementioned parties for compliance, record clarification or explanation, or in response to litigation, summons or subpoenas. I understand that after this information is disclosed, the recipient may re-disclose it resulting in loss of protection by federal regulations. **I agree that my electronic signature serves as my original signature.**

I understand that:

(1) such information will be used by AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS for underwriting and insurability determinations.
(2) I may refuse to sign this authorization and that my refusal to sign will affect my ability to obtain health insurance coverage.
(3) a picture copy or photocopy of this authorization shall be as valid as the original; and
(4) any authorized representative of the Proposed Insured is entitled to receive a copy of this authorization upon request.

This authorization is valid from the date signed for a duration of 24 months. I understand I may revoke the authorization at any time, except to the extent those actions have been taken in reliance on this authorization, by sending written notice to the Health Underwriting Department of AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS, P.O. Box 1991, Galveston, Texas 77553. *I may inspect or copy any information used or disclosed under this authorization, if signed.*

Applicant's Signature _____ Date _____
Spouse's Signature (if coverage is requested for spouse) _____ Date _____
Personal Representative designated by signature above is hereby authorized to execute this instrument based on: power of attorney, guardian-in-fact, guardian, payee representative, other _____ (Circle One).

EZ Enrollment Application to
American National Life Insurance Company of Texas (ANTEX) • Administrative Office • Galveston, Texas

Print in Black ❑ **New** ❑ **Reinstatement-Existing #** _____ ❑ **Change-Existing #** _____

1. Special Requests: Mail Certificate to Applicant: ❑ Yes ❑ No Requested Effective Date: _____

I, as a member of the association, apply for:

2. ❑ Catastrophic Hospital Plan:

Rate of Payment:
❑ 100% ❑ 80% ❑ 50%

Stop-Loss Amount: (Option A only)
❑ $5,000 ❑ $10,000

Per Injury/Sickness Maximum
❑ $2,000,000

❑ **Option A**
Deductible Amount:
❑ $750 ❑ $1,500 ❑ $2,000 ❑ $2,500 ❑ $5,000
❑ $10,000 ❑ $15,000 ❑ $20,000 ❑ $25,000

❑ **Option B** (Family Coverage only)
Deductible Amount:
❑ $3,000 ❑ $4,000 ❑ $5,000
❑ $10,000

PPO Rider ❑ Yes ❑ No
PPO Selected _____

Optional Benefits: *(NON-HSA ONLY)*

Accident Rider:

Max. Amount	Deductible
❑ $500	❑ $100
❑ $1,000	❑ $250
❑ $1,500	❑ $250
❑ $2,500	❑ $500

Childbirth Rider
❑ $1,000 ❑ $2,000

OP Diagnostic Testing Rider: ❑ Yes* ❑ No
Deductible Amount:: ❑ $750 ❑ $1,000 ❑ $1,500

OP Drug Rider: ❑ Yes ❑ No
❑ $500 ❑ $1,000 (Individual Deductible)
❑ $1,000 ❑ $2,000 (Family Deductible)

OP Doctor Rider: ❑ Yes** ❑ No
Deductible Amount: ❑ $750 ❑ $1,000 ❑ $1,500
❑ $2,000 ❑ $2,500 ❑ $3,000
(❑ $4,000 ❑ $5,000 only available with the $100,000 Maximum Benefit)
Maximum Benefit: ❑ $25,000 ❑ $100,000

*(Not available when OP Doctor Rider selected) **(Not available when OP Diagnostic Testing Rider selected)

❑ **HSA Plan:**

Plan Deductible Amount:
Individual: ❑ $1,500 ❑ $2,000
❑ $2,500 ❑ $5,000
Family: ❑ $3,000 ❑ $4,000 ❑ $5,000
❑ $10,000(100% Rate of Pmt.)

Rate of Payment:
❑ 100% ❑ 80% ❑ 50%

Per Injury/Sickness Maximum
❑ $2,000,000

PPO Rider ❑ Yes ❑ No
PPO Selected _____

3. Initial Modal Premium: Amount: $ _____

TO BE COMPLETED PERSONALLY BY THE APPLICANT AND SPOUSE, IF APPLYING.

4. Proposed Insured Information

Proposed Insured(s) (Print Last Name, First Name, MI.)	Relationship	Marital Status Single	Marital Status Married	Sex	Age	Date of Birth Mo.	Date of Birth Day	Date of Birth Year	Place of Birth	Build Height	Build Weight	Social Security Number
1	Applicant	☐	☐									
2	Spouse	☐	☐									
3												
4												
5												
6												

5. Address (Permanent U.S. residence of primary insured.)

Best time to call:

_____
Number and Street or R.F.D.

_____
City State Zip

Phone: Hm ( ) _____ ❑ A.M. ❑ P.M.
Work: ( ) _____ ❑ A.M. ❑ P.M.
Cell: ( ) _____ ❑ A.M. ❑ P.M.

E-Mail Address: _____

6. Employment Data	Employed Full-Time?	Name of Employer *(if self employed, describe duties)*	Duties/Title	Avg. Monthly Earnings Last 12 Months
Applicant	☐ Yes ☐ No			$
Spouse	☐ Yes ☐ No			$

7. Has any Proposed Insured used tobacco or a tobacco based product within the past 12 months? ❑ Yes ❑ No
If "Yes", who? _____

8. Has any Proposed Insured applied for life, accident or health insurance, or reinstatement of such insurance, which was restricted or rated up? ❑ Yes ❑ No
Name _____ Reason _____

9. Are all dependent children under the age of 26 years? ❑ Yes ❑ No
(Do not include on this application any of your children who are 26 years of age or older or any married children)

10. Does any Proposed Insured plan to travel or reside outside the United States? ❑ Yes ❑ No
If "Yes", Who? _____ Where? _____

11. Does any Proposed Insured engage in hazardous occupations or sports? ❑ Yes ❑ No
If "Yes", Who? _____ Details _____

12. Has any person applying been covered under a health insurance plan including COBRA within the last 18 months? ❑ Yes ❑ No

13. Are you applying for coverage under the federal HIPAA Program ❑ Yes ❑ No *(If yes, submit letter of creditable coverage.)*

14. Will this insurance replace any existing insurance or insurance which has terminated with this company or any other company? ❑ Yes ❑ No
(If "yes" to questions 12, 13 or 14, provide details below for coverage in the last 24 months.)

Question #	Name of Company & Policy #	Plan Type Grp. or Ind.	Hospital	Major Medical	Effective Date Month-Year	Termination Date Month-Year

15. You should not cancel your existing medical insurance coverage until you receive written notification of acceptance from ANTEX.
If accepted, do you agree to discontinue your current medical insurance? ❑ Yes ❑ No

CHANGES IN EMPLOYMENT STATUS INDICATED BELOW MAY AFFECT FUTURE ELIGIBILITY FOR INSURANCE COVERAGE.
ALL OF THE FOLLOWING QUESTIONS MUST BE ANSWERED:

16. Are you the owner of an incorporated business? ☐ Yes ☐ No
17. Are you a sole proprietor or a partner in a partnership? ☐ Yes ☐ No
18. Are you an employee of a business? ☐ Yes ☐ No
18a. Will your employer pay a portion of your health insurance premium? ☐ Yes ☐ No
18b. Will you be reimbursed by your employer, through wage adjustments or otherwise, for any portion of the premium? ☐ Yes ☐ No
18c. Will your health insurance plan be treated by you or your employer as part of a plan or program for the purposes of Section 106, 125 or 162, Internal Revenue Code of 1986 (26 U.S.C. Section 106, 125 or 162)? ☐ Yes ☐ No

19. Answer the following questions to determine if your client is eligible for health insurance coverage.

a. Does any Proposed Insured have history of Medical Conditions such as, but not limited to, Internal Cancer, COPD, Connective Tissue Disorder, Crohn's Disease, Diabetes, Elevated Blood Sugar, Emphysema, Heart Attack, Heart Surgery, Heart Disease, Angioplasty, Hepatitis, Organ Transplant, Stroke, Stent Placement, Ulcerative Colitis or Melanoma? ❑ Yes ❑ No

b. Within the last 10 years, has any Proposed Insured ever received a positive diagnosis or been treated for HIV, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? ❑ Yes ❑ No

c. Does any Proposed Insured have surgery or medical tests recommended or pending but not yet performed? ❑ Yes ❑ No

d. Does any Proposed Insured have a history of drug or alcohol abuse within the last 5 years, or had a driver's license suspended, received a DUI/DWI/OUI within the past 2 years? ❑ Yes ❑ No

e. Is any Proposed Insured or household family member (including students away at school whether applying or not applying for coverage) currently pregnant? ❑ Yes ❑ No

f. Has any Proposed Insured not resided in the United States 2 years or more? ❑ Yes ❑ No

If the answer is "Yes" to any of the above questions, do not submit the application for coverage on this individual. If a family member is pregnant, do not submit application for any member.

APPLICATION DECLARATION & AGREEMENTS

I have personally completed this Enrollment Application and represent that all the answers and statements on this Enrollment Application are true, complete, and correctly recorded and agree they will be used to determine the eligibility for coverage applied for, for each Proposed Insured. I understand and agree that: 1) all statements and answers in this Enrollment Application, including any supplements, are complete and true; 2) I have personal knowledge of the medical history of each Proposed Insured; 3) any incorrect or incomplete information in this Enrollment Application may result in loss of coverage or claim denial; 4) no insurance coverage shall take effect unless the coverage applied for becomes effective or requested change is approved by ANTEX and the Certificate or requested change is delivered to the Applicant, and the first full premium paid during the lifetime and good health of all Proposed Insureds. I will notify and provide the Company with any evidence required by it to determine my future eligibility for coverage under the Group Policy. I acknowledge that I have received and read the material describing the rights of the Eligible Individual under the HIPAA mandate, the Fair Credit Reporting Act Pre-Notification, and the MIB Pre-Notification.

Insurance Fraud: - Warning: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

I further understand and agree that:

1. A future change in my employment status may cause me to no longer be eligible for coverage under the Group Policy; and
2. Eligibility for coverage under the Group Policy does not constitute initial coverage under the Group Policy; and
3. Coverage under the Group Policy is subject to ANTEX's underwriting criteria.

Attention Applicant And Spouse:
After this Enrollment Application has been completed, and before you sign it, read it carefully to be certain that all information has been properly recorded. I agree that my electronic signature on this Enrollment Application serves as my original signature.

Signed at _____ Date _____
City State Zip

Applicant's Signature _____ Spouse's Signature _____

Agent Name _____ Code/Writing# _____

Fax# _____ Email _____

AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE MEDICAL INFORMATION

I hereby authorize any physician, medical practitioner, hospital, clinic or other medically related facility, insurance company, insurance support organization, business partner, pharmacy, government agency, group policy holder, employer, benefit plan administrator, MIB, Inc., the Department of Motor Vehicle Registration, and paramedical facility to provide to AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS or to any agent, attorney, consumer reporting agency, or an independent administrator, including medical record retrieval services, pharmaceutical services, acting on behalf of AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS or its reinsurers behalf, information concerning advice, care or treatment sought by or provided to me and/or any other applicant for coverage, including information relating to medical history, medical conditions, treatment, hospitalizations or confinements, ailments, and/or drug, alcohol or tobacco usage of the proposed insured(s). It is understood that AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS underwriters, claims examiners, reinsurers, attorneys or the medical director may disclose such health information to the aforementioned parties for purposes of underwriting, compliance, record clarification or explanation, or in response to litigation, summons or subpoenas. I understand that after this information is disclosed, the recipient may redisclose it resulting in loss of protection by federal regulations. I agree that my electronic signature serves as my original signature.

I understand that:

(1) such information will be used by AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS for underwriting and insurability determinations.
(2) I may refuse to sign this authorization and that my refusal to sign will affect my ability to obtain health insurance coverage.
(3) a picture copy or photocopy of this authorization shall be as valid as the original; and
(4) any authorized representative of the proposed insured is entitled to receive a copy of this authorization upon request.

This authorization is valid from the date signed for a duration of 24 months. I understand I may revoke the authorization at any time, except to the extent that actions have been taken in reliance on this authorization, by sending written notice to the Health Underwriting Department of AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS, P.O. Box 1991, Galveston, Texas 77553. *I may inspect or copy any information used or disclosed under this authorization, if signed.*

Date _____ Applicant's Signature _____

Witness _____ Spouse Signature _____
(if coverage is requested for Spouse)

Personal Representative designated by signature above is hereby authorized to execute this instrument based on: power of attorney, guardian-in-fact, guardian, payee representative, other (Circle One). _____

EZ Personal History Interview Form

American National Life Insurance Company of Texas ◆Galveston, Texas

Please ***Carefully Review*** the EZ Personal History Interview Form to determine if answers are true, complete, and correctly recorded.

Certificate #

Contact information:

American National Life Insurance Company of Texas
Health Underwriting Division
P. O. BOX 1991, Galveston, TX 77553
1-800-899-6805

Section I: Proposed Insured Information

Name(s)	Relationship	Marital Status Single	Married	Sex	Age	DOB	State	Build Height	Weight

Section II: Medical History Verification

1	Please list the last time each Proposed Insured was seen by a physician. Provide details as to why medical care was sought, treatment, and current status of condition. Doctor contact information should include name, address, and phone number.			
Proposed Insured	Yes	No	Description ofChanges/Additions (Include dates of illness/treatment and medications)	Name/address of attending physician

Section III: Medical History and Related Information Continued... **Within the last 10 years, has any Proposed Insured had any diagnosis of or treatment for:**		**Yes**	**No**
2	The lungs or respiratory disorder, including hayfever, allergies, desensitization, sinus infections, reactive airway disease, asthma, bronchitis, tuberculosis, pneumonia, emphysema, or chronic lung disease?		
3	The heart or circulatory disorder, including high blood pressure, high cholesterol, heart attack, heart murmur, heart valve disease or chest pain, irregular heartbeat, transient ischemic attack, varicose veins, phlebitis, or blood clot?		
4	An immune disorder, including but not limited to blood or spleen disorder, anemia, lupus, leukemia, purpura, or lymphoma, connective tissue disorder or clotting disorder?		
5	A digestive or gastrointestinal disorder including ulcers, gastritis, reflux disorder, Crohn's Disease, ulcerative colitis, cirrhosis, irritable bowel syndrome, hemorrhoids, hernia, or any disorder of the pancreas, liver, rectum or gallbladder?		
6	A nervous disorder, including epilepsy, convulsions, seizures, tremors, headaches, migraines, paralysis, or stroke?		
7	A mental disorder including emotional problems, eating disorder, attention deficit disorder, hyperactivity, anxiety, autism, depression, sleep disorder, psychiatric treatment or counseling?		
8	An endocrine disorder including diabetes, high or low blood sugar, glucose intolerance or any disorder of the thyroid gland, or any other glandular disorder including adrenal or pituitary?		
9	A genito-urinary tract disorder, including urinary tract stones, bladder or urinary tract infections, renal reflux, incontinence or blood in the urine?		
10	A muscular or skeletal disorder including the bones, joints, back or spine, including manipulation therapy, any muscular or neuromuscular disorder, including arthritis, gout, rheumatism, fibromyalgia or motor skill delay?		
11	Any disorder of the facial bones, upper or lower jaw including temporomandibular joint disease (TMJ)?		
12	Cancer in any form, carcinoma in situ, or tumor, polyp, cyst, growth, scars, keloid, hemangiomas, acne, dermatitis, or any kind, skin disorder?		
13	Any disorder of the eyes, ears, nose or throat, cataracts, glaucoma, ear infections, ear tubes, hearing impairment, enlarged tonsils/adnoids, tonsilitis, vertigo, sleep apnea, speech impediment or deviated nasal septum?		
14	Does any person have any fixation/prosthetic devices present including but not limited to plates, screws, pins, implants, shunts, pacemakers, valve replacements, or stents?		
15	Does any proposed insured have a mental or physical impairment or deformity, or a congenital abnormality or developmental delay, disease or trait not previously disclosed?		

Section IV: Medical History and Related Information Continued...			
With in the past ten (10) years, have you:			
16	Been diagnosed as having AIDS or an AIDS-related condition?		
17	Received a positive result on an HIV test?		
FOR MALE PROPOSED INSURED(S) ONLY:			
18	Any disorder or condition of male reproductive organs or prostate, elevated PSA test, infertility, impotence, or a sexually trasmitted disease?		
FOR FEMALE PROPOSED INSURED(S) ONLY:			
19	Any disorder or condition of the female reproductive organs, abnormal PAP smear, irregular or excessive menstruation, endometriosis, infertility, pregnancy complications including Cesarean section Delivery, cystocele, rectocele, pelvic relaxation, dysmenorrhea, chronic pelvic pain, HPV (human papilloma virus), or a sexually transmitted disease?		
20	Date of last PAP smear?		
21	Have you been instructed to have a repeat PAP smear or any follow-up treatment or tests as a result of your last PAP smear?		
22	Breast disorder, disease, changes, condition lump(s), aspiration(s), calcifications, biopsies, including removal or placement of breast implants or mammoplasty?		

Section V: Medical History and Related Information Continued...			
With in the past 5 years, has any proposed insured:			
23	Been hospital confined, had surgery, advised to undergo further testing, treatment, or surgery, including cosmetic, or reconstructive surgery?		
24	Had an EKG, MRI, chest x-ray, blood study, contacted or seen a physician, psychologist, chiropractor, counselor, therapist, or any other person providing health care services?		
Within the past 12 months, has any proposed insured experienced or been treated by a physician for:			
25	Weight gain or loss of more than 12 pounds?		
Within the last six months:			
26	Has any proposed insured taken any prescription medication or now taking prescription medication or receiving treatment of any kind for any condition not listed above?		
Has any proposed insured ever been:			
27	Treated or counseled for alcohol or drug use or attended a drug or alcohol support group?		
28	Advised by a physician to seek treatment or discontinue or decrease alcohol or drug consumption?		
29	Under the influence of marijuana, narcotics, barbiturates, amphetamines, hallucinogens or used any other drugs not prescribed by a physician?		

Additional Medical Details Recorded by Interviewer...
(List Question #, Name of Proposed Insured, and details to YES responses.)

SUPPLEMENTAL QUESTIONS	Yes	No
Did you review all your answers on the EZ Enrollment Application form prior to submission?		
Did you personally complete the information on EZ Enrollment Application form?		
Were you advised by the agent or anyone not to fully disclose any information?		
Do you understand you are required to be a member of the Association?		
Do you understand that dues and fees are required as a part of being a member to the Association?		
Do you understand the EZ Enrollment Application is under review with the underwriting department and you have no coverage with ANTEX unless approved by the Company?		
If coverage is approved, a contract will be issued based on your signed declaration and only benefits described in the contract will be available. Do you understand and agree?		
You will be given ten(10) days to review the material to make sure the benefits provided are the same as what you understood them to be at the time you applied for coverage. Also during this ten(10) day free look period, you may return the certificate for a full refund of premium. Do you understand and agree?		
Is there anything related to the questions asked of you that you do not understand?		

Additional Comments and Change requests:

DECLARATION FOR EZ PERSONAL HISTORY INTERVIEW:

IT IS DECLARED that statements and answers in the EZ Personal History Interview Application are complete and true to the best knowledge and belief of the undersigned. All questions on the EZ Personal History Interview Application are correctly recorded and it is agreed they will be used to determine the eligibility for coverage under the health insurance plan for which each Proposed Insured is applying. I understand and agree that: (1) "Proposed Insured" means all persons named in Section 1; (2) all statements and answers in this form and any supplements or amendments to it are complete and true; (3) I/we have personal knowledge of the medical history of each proposed insured; (4) any incorrect or incomplete information on the EZ Personal History Interview Application may result in loss of coverage or claim denial; (5) no insurance shall take effect unless the certificate is issued and actually delivered to the Proposed Insured(s) and the first full premium paid during the life time and good health of all Proposed Insured(s). I will notify and provide the Company with any evidence required by it to determine my/our future eligibility under the plan. I also understand and agree that initial coverage under the Group Policy is subject to the Company's underwriting criteria.

ATTENTION PROPOSED INSURED: Before you show your acceptance by signing this Declaration, reread all information carefully to be certain that all information has been properly recorded.

I/we agree that the questions and answers on the EZ Enrollment Application and the EZ Personal History Interview Form are complete and true to the best of my/our knowledge. All recorded personal health history is the basis for the offer of coverage along with the EZ Personal History Interview Form and any attached amendments. It is further agreed that :

1. I/we have reviewed the information provided at the time of the EZ Personal History Interview;
2. the information is complete and recorded correctly; and
3. this information is made a part of the Certificate which evidences coverage under the group plan.

Signed at_____Date_____Proposed Insured's Signature_____

Signed at_____Date_____Spouse's Signature_____

ATTENTION AGENT: Before you FAX in the *Signed* Declaration, please verify the following has been completed by checking each box below:

☐	I have personally witnessed/verified the reading of the EZ Personal History Interview Form.
☐	I have collected any additional premium due (if any).
☐	I have explained how to reach ANTEX if the client has any additional questions about their coverage.

Soliciting Agent (Please print clearly)_____Agent's Signature_____
Soliciting Agent PC#:_____Agent's Signature_____
Fax #:_____E-mail Address (please print clearly):_____

Please fax completed and signed Declaration to:
1-800-660-7948

Note to AGENT: *If any health history has changed since completing the EZ Personal History Interview Form or if any health history details are omitted and/or not recorded correctly in the EZ Personal History Interview Form* - Contact the Underwriting Department immediately at:
1-866-214-6973

EZ Personal History Interview Form

American National Life Insurance Company of Texas ◆Galveston, Texas

Please ***Carefully Review*** the EZ Personal History Interview Form to determine if answers are true, complete, and correctly recorded.

Certificate #

Contact information:

American National Life Insurance Company of Texas
Health Underwriting Division
P. O. BOX 1991, Galveston, TX 77553
1-800-899-6805

Section I: Proposed Insured Information

Name(s)	Relationship	Marital Status Single	Married	Sex	Age	DOB	State	Build Height	Weight

Section II: Medical History Verification

1	Please list the last time each Proposed Insured was seen by a physician. Provide details as to why medical care was sought, treatment, and current status of condition. Doctor contact information should include name, address, and phone number.			
Proposed Insured	Yes	No	Description ofChanges/Additions (Include dates of illness/treatment and medications)	Name/address of attending physician

Section III: Medical History and Related Information Continued... **Within the last 10 years, has any Proposed Insured had any diagnosis of or treatment for:**		**Yes**	**No**
2	The lungs or respiratory disorder, including hayfever, allergies, desensitization, sinus infections, reactive airway disease, asthma, bronchitis, tuberculosis, pneumonia, emphysema, or chronic lung disease?		
3	The heart or circulatory disorder, including high blood pressure, high cholesterol, heart attack, heart murmur, heart valve disease or chest pain, irregular heartbeat, transient ischemic attack, varicose veins, phlebitis, or blood clot?		
4	An immune disorder, including but not limited to blood or spleen disorder, anemia, lupus, leukemia, purpura, or lymphoma, connective tissue disorder or clotting disorder?		
5	A digestive or gastrointestinal disorder including ulcers, gastritis, reflux disorder, Crohn's Disease, ulcerative colitis, cirrhosis, irritable bowel syndrome, hemorrhoids, hernia, or any disorder of the pancreas, liver, rectum or gallbladder?		
6	A nervous disorder, including epilepsy, convulsions, seizures, tremors, headaches, migraines, paralysis, or stroke?		
7	A mental disorder including emotional problems, eating disorder, attention deficit disorder, hyperactivity, anxiety, autism, depression, sleep disorder, psychiatric treatment or counseling?		
8	An endocrine disorder including diabetes, high or low blood sugar, glucose intolerance or any disorder of the thyroid gland, or any other glandular disorder including adrenal or pituitary?		
9	A genito-urinary tract disorder, including urinary tract stones, bladder or urinary tract infections, renal reflux, incontinence or blood in the urine?		
10	A muscular or skeletal disorder including the bones, joints, back or spine, including manipulation therapy, any muscular or neuromuscular disorder, including arthritis, gout, rheumatism, fibromyalgia or motor skill delay?		
11	Any disorder of the facial bones, upper or lower jaw including temporomandibular joint disease (TMJ)?		
12	Cancer in any form, carcinoma in situ, or tumor, polyp, cyst, growth, scars, keloid, hemangiomas, acne, dermatitis, or any kind, skin disorder?		
13	Any disorder of the eyes, ears, nose or throat, cataracts, glaucoma, ear infections, ear tubes, hearing impairment, enlarged tonsils/adnoids, tonsilitis, vertigo, sleep apnea, speech impediment or deviated nasal septum?		
14	Does any person have any fixation/prosthetic devices present including but not limited to plates, screws, pins, implants, shunts, pacemakers, valve replacements, or stents?		
15	Does any proposed insured have a mental or physical impairment or deformity, or a congenital abnormality or developmental delay, disease or trait not previously disclosed?		

Section IV: Medical History and Related Information Continued...			
With in the past ten (10) years, have you:			
16	Been diagnosed as having AIDS or an AIDS-related condition?		
17	Received a positive result on an HIV test?		
FOR MALE PROPOSED INSURED(S) ONLY:			
18	Any disorder or condition of male reproductive organs or prostate, elevated PSA test, infertility, impotence, or a sexually trasmitted disease?		
FOR FEMALE PROPOSED INSURED(S) ONLY:			
19	Any disorder or condition of the female reproductive organs, abnormal PAP smear, irregular or excessive menstruation, endometriosis, infertility, pregnancy complications including Cesarean section Delivery, cystocele, rectocele, pelvic relaxation, dysmenorrhea, chronic pelvic pain, HPV (human papilloma virus), or a sexually transmitted disease?		
20	Date of last PAP smear?		
21	Have you been instructed to have a repeat PAP smear or any follow-up treatment or tests as a result of your last PAP smear?		
22	Breast disorder, disease, changes, condition lump(s), aspiration(s), calcifications, biopsies, including removal or placement of breast implants or mammoplasty?		

Section V: Medical History and Related Information Continued...			
With in the past 5 years, has any proposed insured:			
23	Been hospital confined, had surgery, advised to undergo further testing, treatment, or surgery, including cosmetic, or reconstructive surgery?		
24	Had an EKG, MRI, chest x-ray, blood study, contacted or seen a physician, psychologist, chiropractor, counselor, therapist, or any other person providing health care services?		
Within the past 12 months, has any proposed insured experienced or been treated by a physician for:			
25	Weight gain or loss of more than 12 pounds?		
Within the last six months:			
26	Has any proposed insured taken any prescription medication or now taking prescription medication or receiving treatment of any kind for any condition not listed above?		
Has any proposed insured ever been:			
27	Treated or counseled for alcohol or drug use or attended a drug or alcohol support group?		
28	Advised by a physician to seek treatment or discontinue or decrease alcohol or drug consumption?		
29	Under the influence of marijuana, narcotics, barbiturates, amphetamines, hallucinogens or used any other drugs not prescribed by a physician?		

Additional Medical Details Recorded by Interviewer...
(List Question #, Name of Proposed Insured, and details to YES responses.)

SUPPLEMENTAL QUESTIONS	Yes	No
Did you review all your answers on the EZ Enrollment Application form prior to submission?		
Did you personally complete the information on EZ Enrollment Application form?		
Were you advised by the agent or anyone not to fully disclose any information?		
Do you understand you are required to be a member of the Association?		
Do you understand that dues and fees are required as a part of being a member to the Association?		
Do you understand the EZ Enrollment Application is under review with the underwriting department and you have no coverage with ANTEX unless approved by the Company?		
If coverage is approved, a contract will be issued based on your voice signature and only benefits described in the contract will be available. Do you understand and agree?		
You will be given ten(10) days to review the material to make sure the benefits provided are the same as what you understood them to be at the time you applied for coverage. Also during this ten(10) day free look period, you may return the certificate for a full refund of premium. Do you understand and agree?		
Is there anything related to the questions asked of you that you do not understand?		

Additional Comments and Change requests:

VOICE SIGNATURE CONFIRMATION

You have consented to the use of your voice signature as part of this application.

We accept your voice signature as your electronic signature attesting to your answers.

The answers you have given will be transcribed as a part of the EZ Personal History Interview Form and become a part of our health insurance contract along with the EZ Enrollment Application. These form the basis of your insurability.

You have personal knowledge of the medical history of each proposed insured and that any incorrect or incomplete information provided during the personal history interview and recorded on the EZ Personal History Interview Form may result in loss of coverage or claim denial.

You represent that the answers provided during the interview are true and correct and complete as they relate to each person to be insured.

You will contact the underwriting department immediately if there has been a change in health history or if you find an error or omission in the delivered contract, if approved.

Please note that continued payment of premium will constitute acceptance of this coverage.

Name of Proposed Insured Interviewed:_____

DOB:_____

Last 4 Digits of SSN:_____

Interview completed by:_____**Date:**_____

Note! *If any health history has changed since completing the EZ Personal History Interview Form or if any health history details are omitted and/or not recorded correctly in the EZ Personal History Interview Form -* Contact the Underwriting Department immediately at: **1-866-214-6973**

AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS
HOME OFFICE: ONE MOODY PLAZA
GALVESTON, TEXAS

OUTPATIENT ACCIDENT EXPENSE BENEFIT RIDER

This Rider is made a part of the Group Policy or Certificate to which it is attached. This Rider is subject to all non-conflicting Group Policy provisions, terms, definitions and limitations. Unless otherwise indicated below, this Rider is effective on the Certificate Date

ACCIDENT means an act or event which is unforeseen, unexpected and unanticipated by a Covered Person and to which the accidental bodily Injury is attributable.

OUTPATIENT means a Covered Person is neither Hospital Confined nor a patient at a Same Day Surgery Facility.

BENEFIT - We will pay the Reasonable and Customary Charges in excess of this Rider's Deductible Amount, shown in Your Certificate Schedule, when such charges are incurred by a Covered Person for the Medically Necessary Outpatient treatment of a covered Injury resulting from an Accident. Benefits are payable up to this Rider's Maximum Benefit Per Accident shown in Your Certificate Schedule. This benefit is subject to the following conditions:

1. Initial treatment by a Doctor must begin within forty-eight (48) hours of the Accident; and
2. Subsequent treatment must be received within thirty (30) days of the Accident.

The benefits that this Rider provides will not duplicate any similar benefits provided under the Group Policy. Benefits payable under this Rider are not subject to the Group Policy's Deductible Amount or Rate of Payment. The total benefits paid under the Group Policy, and this or any other Rider, will not be greater than the actual expense incurred.

Coverage under this Rider expires concurrently with Your coverage under the Group Policy, unless while Your coverage under the Group Policy is still in effect, You notify ANTEX in writing to terminate coverage under this Rider or this Rider is otherwise modified, cancelled or replaced by ANTEX or the Group Policyholder in accordance with the terms of the Group Policy.

Effective Date, if other than Your Certificate Date: _____

Signed on behalf of American National Life Insurance Company of Texas at Galveston, Texas.

Secretary

SCHEDULE PAGE LANGUAGE:

ANL-ACC09 – OUTPATIENT ACCIDENT EXPENSE RIDER

DEDUCTIBLE AMOUNT PER COVERED PERSON PER ACCIDENT – [$100, $250, or $500]

MAXIMUM BENEFIT PER ACCIDENT – [$500, $1,000, $1,500, or$2,500]

AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS
HOME OFFICE: ONE MOODY PLAZA
GALVESTON TEXAS

CHILDBIRTH BENEFIT RIDER

This Rider is made a part of the Group Policy or Certificate to which it is attached. This Rider is subject to all non-conflicting Group Policy provisions, terms, definitions and limitations. Unless otherwise indicated below, this Rider is effective on the Certificate Date.

We will consider Eligible Expenses due to a Covered Person's pregnancy if: (1) a Doctor determines that the pregnancy began more than 30 days after the Rider Effective Date; and (2) the pregnancy terminates while this Rider is in force.

A. We pay Eligible Expenses for normal delivery, up to the **MAXIMUM BENEFIT PER CHILDBIRTH**, which is shown on Your Certificate Schedule. This benefit is not subject to the Deductible Amount or Rate of Payment.

B. We pay Eligible Expenses, for a voluntary Cesarean Section, up to 150% of the **MAXIMUM BENEFIT PER CHILDBIRTH**, which is shown on Your Certificate Schedule.

When expenses incurred qualify for benefits under both paragraph A and B, only the paragraph describing the largest benefit will apply.

Complications of Pregnancy are covered under the Group Policy. A voluntary Cesarean Section is not a Complication of Pregnancy.

The benefits that this Rider provides will not duplicate any similar benefits provided under the Group Policy. The total benefits paid under the Group Policy, and this or any other Rider, will not be greater than the actual expense incurred.

Coverage under this Rider expires concurrently with Your coverage under the Group Policy, unless while Your coverage under the Group Policy is still in effect, You notify ANTEX in writing to terminate coverage under this Rider or this Rider is otherwise modified, cancelled or replaced by ANTEX or the Group Policyholder in accordance with the terms of the Group Policy.

Effective Date, if other than Your Certificate Date: _____

Signed on behalf of American National Life Insurance Company of Texas at Galveston, Texas.

Secretary

RIDER SCHEDULE PAGE LANGUAGE:

ANL-CBB09 – CHILDBIRTH BENEFIT RIDER
MAXIMUM BENEFIT PER CHILDBIRTH – ($1,000, $2,000)

AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS
HOME OFFICE: ONE MOODY PLAZA
GALVESTON, TEXAS

OUTPATIENT DIAGNOSTIC IMAGING RIDER

This Rider is made a part of the Group Policy or Certificate to which it is attached. This Rider is subject to all non-conflicting Group Policy provisions, terms, definitions, and limitations. Unless otherwise indicated below, this Rider is effective on the Certificate Date.

DIAGNOSTIC IMAGING means Magnetic Resonance Imaging (**MRI**), Magnetic Resonance Angiography (**MRA**), Computed Axial Tomography (**CAT** Scans), Positron Emission Tomography (**PET** Scans), or Computed Tomography (**CT** scans).

OUTPATIENT means a Covered Person is neither Hospital Confined nor a patient at a Same Day Surgery Facility.

BENEFIT

Benefits are payable under this Rider once the Reasonable and Customary Charges incurred by a Covered Person for Medically Necessary Diagnostic Imaging exceed this Rider's Calendar Year Deductible Amount shown in Your Certificate Schedule. We then pay [80%] of such remaining charge up to the Calendar Year Rider Maximum shown in Your Certificate Schedule.

Procedures other than Diagnostic Imaging are excluded under this Rider. The benefits this Rider provides will not duplicate any similar benefits provided under the Group Policy. Benefits payable under this Rider are not subject to the Group Policy's Deductible Amount or Rate of Payment. The total benefits paid under the Group Policy and this, or any other, Rider will not be greater than the actual expense incurred.

Coverage under this Rider expires concurrently with Your coverage under the Group Policy, unless while Your coverage under the Group Policy is still in effect, You notify ANTEX in writing to terminate coverage under this Rider or this Rider is otherwise modified, cancelled or replaced by ANTEX or the Group Policyholder in accordance with the terms of the Group Policy.

Effective Date, if other than Your Certificate Date: _____

Signed on behalf of American National Life Insurance Company of Texas at Galveston, Texas.

Secretary

RIDER SCHEDULE PAGE LANGUAGE:

ANL-DIR09 – OUTPATIENT DIAGNOSTIC IMAGING RIDER

CALENDAR YEAR DEDUCTIBLE AMOUNT PER COVERED PERSON -
($750, $1,000, $1,500. $2,000, $2,500, $3,000, $4,000, $5,000)
RIDER MAXIMUM - $25,000

AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS
HOME OFFICE: ONE MOODY PLAZA
GALVESTON, TEXAS

AMENDMENT

This Amendment is made a part of the Group Policy or Certificate to which it is attached. This Amendment is subject to all non-conflicting Group Policy provisions, terms, definitions and limitations. Unless otherwise indicated below, this Amendment is effective on the Certificate Date.

The section of the Group Policy and Certificate called "**BENEFITS**" is herby replaced, in its entirety, by the following:

WHAT WE PAY – We pay benefits at the Rate of Payment after a Covered Person incurs charges during a Calendar Year for Medical Services in excess of the Deductible Amount. If the selected Rate of Payment is less than 100%, the Covered Person must meet the Unpaid Medical Services Maximum before We begin to pay at a 100% Rate of Payment for the remainder of the Calendar Year. The Unpaid Medical Services Maximum is shown on Your Certificate Schedule. All benefits payable under the Group Policy are subject to the Policy Maximum Benefit Payments.

DEDUCTIBLE AMOUNT – The Deductible Amount is shown in the Policy Schedule. The Deductible Amount is the amount of Medical Service charges a Covered Person must incur each Calendar Year before We pay benefits. There is an Individual Deductible Amount if You are the only Covered Person and a Family Deductible Amount if there are other Covered Persons in addition to You. The Deductible may be met by one Covered Person or collectively by all Covered Persons if family coverage is provided. Once charges for Medical Services in a Calendar Year exceed the Deductible Amount, there is no additional Deductible Amount required to be met by any Covered Person during the remainder of the Calendar Year.

NOTICE: THE DEDUCTIBLE AMOUNT WILL CHANGE IN ACCORDANCE WITH FEDERAL REQUIREMENTS.

RATE OF PAYMENT – This is the percentage of benefits payable for Medical Services after the Deductible Amount is met. If the selected Rate of Payment is less than 100%, You are responsible for any balance (the Unpaid Medical Service Charges). The Policy Schedule shows the Rate of Payment.

UNPAID MEDICAL SERVICES MAXIMUM – This is the maximum amount that You pay each Calendar Year comprised of charges for Medical Services applied to the Deductible Amount and Rate of Payment for Medical Services before We pay 100% of Medical Services charges. There is an Individual or a Family Unpaid Medical Services Maximum depending on whether family coverage is provided. Once Covered Persons have met the Family Unpaid Medical Services Maximum, individually or collectively, We will pay 100% of charges for Medical Services for all Covered Persons for the remainder of the Calendar Year. The Policy Schedule shows the Unpaid Medical Services Maximum. **We <u>do not</u> apply the following toward the Unpaid Medical Services Maximum: any non-Medical Service charge or ineligible expense.**

NOTICE: THE UNPAID MEDICAL SERVICES MAXIMUM WILL CHANGE IN ACCORDANCE WITH FEDERAL REQUIREMENTS.

The section of the Group Policy and Certificate called "**MEDICAL SERVICES**" is herby amended by deleting **MAMMOGRAM** in its entirety and replacing it with the following:

Mammogram - Reasonable and Customary Charges for one annual screening mammogram per Calendar Year. We pay the benefit whether or not the Covered Person is Hospital Confined.

Coverage under this Amendment expires concurrently with Your coverage under the Group Policy.

Effective Date, if other than Your Certificate Date: _____

Signed on behalf of American National Life Insurance Company of Texas at Galveston, Texas.

J. Mark Flippin

Secretary

ANL-HQA09

AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS
HOME OFFICE: ONE MOODY PLAZA
GALVESTON, TEXAS

PREFERRED PROVIDER RIDER

This Rider is made a part of the Group Policy or Certificate to which it is attached. This Rider is subject to all non-conflicting Group Policy provisions, terms, definitions and limitations. Unless otherwise indicated below, this Rider is effective on the Certificate Date.

Your insurance coverage is provided as PPO Coverage. For purposes of this Rider, the following definitions are added to the Group Policy:

IN-NETWORK means use of a provider within the PPO.

OUT-OF-NETWORK means use of a provider outside of the PPO.

PPO means a Preferred Provider Organization. The Company names the PPO that You and other Covered Persons may use. A PPO may include Doctors, Hospitals, Ambulatory Surgery Facilities and other types of medical facilities. The PPO provides medical care or services at a negotiated rate in consideration of an agreement with the Company. The Company initially names the PPO on the Certificate Date but may change it from time to time. We will notify You in writing before We name a new PPO.

The definition "**REASONABLE AND CUSTOMARY CHARGES**" is replaced by the following:

REASONABLE AND CUSTOMARY CHARGES means the charge that is the smallest of:

1. The actual charge;
2. The charge usually made for the covered service by the provider who furnishes it;
3. The prevailing charge made for a covered service in a geographical area by those of similar professional standing; or
4. The negotiated rate in effect with a PPO on the date it provides a covered service.

IN-NETWORK CARE – The Company pays benefits at the In-Network Rate of Payment for charges incurred for:

1. Hospital Confinement in an In-Network Hospital;
2. Outpatient surgery in an In-Network Same Day Surgery Facility;
3. Doctor services provided by an In-Network Doctor.

OUT-OF-NETWORK CARE - When a Covered Person is admitted to an Out-of-Network Hospital, uses an Out-of-Network Same Day Surgery Facility, or receives treatment from an Out-of-Network Doctor; the Company pays benefits at the Out-of-Network Rate of Payment, which is lower than the In-Network Rate of Payment. In order to receive the maximum benefit payable, charges must be received In-Network. However, In the event of an Emergency, Out-of-Network charges are considered In-Network and payable at the In-Network Rate of Payment.

The In-Network and Out-of-Network Rate of Payments are shown on the Certificate Schedule.

Reduction in benefits described in this Rider do not apply to benefits that may be provided under other optional riders providing coverage to You and/or Covered Persons.

Coverage under this Rider expires concurrently with Your coverage under the Group Policy, unless while Your coverage under the Group Policy is still in effect, You notify ANTEX in writing to terminate coverage under this Rider or this Rider is otherwise modified, cancelled or replaced by ANTEX or the Group Policyholder in accordance with the terms of the Group Policy.

Effective Date, if other than Your Certificate Date: _____

Signed on behalf of American National Life Insurance Company of Texas at Galveston, Texas.

Secretary

AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS
HOME OFFICE: ONE MOODY PLAZA
GALVESTON, TEXAS

PPO RIDER

This Rider is made a part of the Group Policy or Certificate to which it is attached. This Rider is subject to all non-conflicting Group Policy provisions, terms, definitions and limitations. Unless otherwise indicated below, this Rider is effective on the Certificate Date.

Your insurance coverage is provided as PPO Coverage. For purposes of this Rider, the following definitions are added to the Group Policy:

IN-NETWORK means use of a provider within the PPO.

OUT-OF-NETWORK means use of a provider outside of the PPO.

PPO means a Preferred Provider Organization. The Company names the PPO that You and other Covered Persons may use. A PPO may include Doctors, Hospitals, Ambulatory Surgery Facilities and other types of medical facilities. The PPO provides medical care or services at a negotiated rate in consideration of an agreement with the Company. The Company initially names the PPO on the Certificate Date but may change it from time to time. We will notify You in writing before We name a new PPO.

The definition "**REASONABLE AND CUSTOMARY CHARGES**" is replaced by the following:

REASONABLE AND CUSTOMARY CHARGES means the charge that is the smallest of:

1. The actual charge;
2. The charge usually made for the covered service by the provider who furnishes it;
3. The prevailing charge made for a covered service in a geographical area by those of similar professional standing; or
4. The negotiated rate in effect with a PPO on the date it provides a covered service.

OUT-OF-NETWORK PENALTY – Coverage under the Group Policy includes a PPO component. You are encouraged to use an in-network provider to receive the maximum amount payable for eligible Medical Service Charges. Use of an Out-Of-Network provider results in a 20% reduction of any otherwise eligible Medical Service Charge that we do not pay due to a Covered Person's voluntary use of an Out-Of-Network provider.

Coverage under this Rider expires concurrently with Your coverage under the Group Policy, unless while Your coverage under the Group Policy is still in effect, You notify ANTEX in writing to terminate coverage under this Rider or this Rider is otherwise modified, cancelled or replaced by ANTEX or the Group Policyholder in accordance with the terms of the Group Policy.

Effective Date, if other than Your Certificate Date: _____

Signed on behalf of American National Life Insurance Company of Texas at Galveston, Texas.

Secretary

AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS
HOME OFFICE: ONE MOODY PLAZA
GALVESTON, TEXAS

PPO RIDER

This Rider is made a part of the Group Policy or Certificate to which it is attached. This Rider is subject to all non-conflicting Group Policy provisions, terms, definitions and limitations. Unless otherwise indicated below, this Rider is effective on the Certificate Date.

Your insurance coverage is provided as PPO Coverage. For purposes of this Rider, the following definitions are added to the Group Policy:

IN-NETWORK means use of a provider within the PPO.

OUT-OF-NETWORK means use of a provider outside of the PPO.

PPO means a Preferred Provider Organization. The Company names the PPO that You and other Covered Persons may use. A PPO may include Doctors, Hospitals, Ambulatory Surgery Facilities and other types of medical facilities. The PPO provides medical care or services at a negotiated rate in consideration of an agreement with the Company. The Company initially names the PPO on the Certificate Date but may change it from time to time. We will notify You in writing before We name a new PPO.

The definition "**REASONABLE AND CUSTOMARY CHARGES**" is replaced by the following:

REASONABLE AND CUSTOMARY CHARGES means the charge that is the smallest of:

1. The actual charge;
2. The charge usually made for the covered service by the provider who furnishes it;
3. The prevailing charge made for a covered service in a geographical area by those of similar professional standing; or
4. The negotiated rate in effect with a PPO on the date it provides a covered service.

OUT-OF-NETWORK PENALTY – Coverage under the Group Policy includes a PPO component. You are encouraged to use an in-network provider to receive the maximum amount payable for eligible Medical Service Charges. Use of an Out-Of-Network provider results in a 20% reduction of any otherwise eligible Medical Service Charge that we do not pay due to a Covered Person's voluntary use of an Out-Of-Network provider.

Coverage under this Rider expires concurrently with Your coverage under the Group Policy, unless while Your coverage under the Group Policy is still in effect, You notify ANTEX in writing to terminate coverage under this Rider or this Rider is otherwise modified, cancelled or replaced by ANTEX or the Group Policyholder in accordance with the terms of the Group Policy.

Effective Date, if other than Your Certificate Date: _____

Signed on behalf of American National Life Insurance Company of Texas at Galveston, Texas.

Secretary

AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS
HOME OFFICE: ONE MOODY PLAZA
GALVESTON, TEXAS

RESTORATION OF BENEFITS RIDER

This Rider is made a part of the Group Policy or Certificate to which it is attached. This Rider is subject to all non-conflicting Group Policy provisions, terms, definitions and limitations. Unless otherwise indicated below, this Rider is effective on the Certificate Date

RESTORATION OF BENEFIT - Each January 1st following a Calendar Year where benefits for a Covered Person have been paid under the Group Policy, the value of such Covered Person's Maximum Policy Benefit for Each Injury or Sickness per Covered Person, shown in Your Certificate Schedule and otherwise reduced by the amount of actual claims paid, will be restored by the lesser of:

1. The amount of actual claims payable for a such Covered Person during the preceding Calendar Year; or
2. [$100,000].

This Restoration only applies to an individual who is a Covered Person on January 1st of the Calendar Year when the Restoration of Benefits occurs. .

Coverage under this Rider expires concurrently with Your coverage under the Group Policy, unless while Your coverage under the Group Policy is still in effect, You notify ANTEX in writing to terminate coverage under this Rider or this Rider is otherwise modified, cancelled or replaced by ANTEX or the Group Policyholder in accordance with the terms of the Group Policy.

Effective Date, if other than Your Certificate Date: _____

Signed on behalf of American National Life Insurance Company of Texas at Galveston, Texas.

Secretary

AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS
HOME OFFICE: ONE MOODY PLAZA
GALVESTON, TEXAS

OUTPATIENT DOCTOR RIDER

This Rider is made a part of the Group Policy or Certificate to which it is attached. This Rider is subject to all non-conflicting Group Policy provisions, terms, definitions and limitations. Unless otherwise indicated below, this Rider is effective on the Certificate Date.

The benefits that this Rider provides will not duplicate any similar benefits provided under the Group Policy. Benefits payable under this Rider are not subject to the Group Policy's Deductible Amount or Rate of Payment. The total benefits paid under the Group Policy, and this or any other Rider, will not be greater than the actual expense incurred.

OUTPATIENT means a Covered Person is neither Hospital Confined nor a patient at a Same Day Surgery Facility.

BENEFIT – Benefits are payable under this Rider when a Covered Person incurs expenses for Outpatient Rider Services, described below, for the Medically Necessary treatment of Injury or Sickness. Payment of benefits under this Rider is limited to the Rate of Payment for this Rider for the Reasonable and Customary Charge for Rider Services received in excess of the Calendar Year Deductible for this Rider, also shown in Your Certificate Schedule.

RIDER SERVICES are:

1. Hospital Emergency room or other Outpatient clinic;
2. Doctor;
3. Anesthesia, including administration charges, for a Covered Person undergoing Outpatient surgery
4. Charges for Outpatient diagnostic tests;
5. Miscellaneous supplies including casts, splints, braces, hypodermics, and crutches;
   Charges for prescription drugs taken or administered within 30 days of a Hospital Stay for treatment of the condition for which You were Hospital Confined, including: (1) medication and supplies for the treatment of Type I, Type II, or gestational diabetes, when Doctor prescribed and (2) prescription contraceptives. Benefits paid under this provision will not be duplicated with benefits paid under any other Rider;
   Charges for the Medically Necessary treatment of Type I, Type II, or gestational diabetes.
6. Charges for one per lifetime self-management diabetes training program per Covered Person when Medically Necessary as determined by a Doctor. Additional training is covered when a Doctor prescribes the additional training as Medically Necessary because of a significant change in the Covered Person's symptoms or conditions.

   "Diabetes self-management training" means instruction in an outpatient setting including medical nutrition therapy relating to diet, caloric intake and diabetes management, excluding programs the primary purposes of which are weight reduction, which enables diabetic patients to understand the diabetic management process and daily management of diabetic therapy as a method of avoiding frequent hospitalizations and complications when the instruction is provided in accordance with a program in compliance with the National Standards for Diabetes Self-Management Education Program as developed by the American Diabetes Association.
7. Charges incurred for necessary care and treatment of loss or impairment of speech or hearing. Coverage does not include hearing instruments or devices.
8. If the Group Policy provides coverage for persons other than Yourself, benefits include charges for Periodic Children's Preventive Care Services for Covered Persons on a periodic basis that will include twenty (20) Periodic Preventive Care Visits at approximately the following age intervals: birth; two (2) weeks; two (2) months; four (4) months; six (6) months; nine (9) months; twelve (12) months; fifteen (15) months; eighteen (18) months; two (2) years; three (3) years; four (4) years; five (5) years; six (6) years; eight (8) years; ten (10) years; twelve (12) years; fourteen (14) years; sixteen (16) years; and eighteen (18) years. Immunization services are not subject to any Deductible, Coinsurance Amount, or Maximum. All other Children's Preventive Health Care Eligible Expenses are subject to this Rider's Cash Deductible, Coinsurance Amount, and Maximum.

   "Children's Preventive Health Care Services" means Doctor-delivered or Doctor-supervised services for eligible dependents from birth through eighteen (18) years of age, with Periodic Preventive Care Visits, including medical history, physical examination, developmental assessment, anticipatory guidance, and appropriate immunizations and laboratory tests, in keeping with prevailing medical standards for the purposes of this section.

"Periodic Preventive Care Visits" means the routine tests and procedures for the purpose of detection of abnormalities or malfunctions of bodily systems and parts according to accepted medical practice.

9. Charges for colorectal cancer examinations and laboratory tests for: (1) Covered Persons who are 50 years of age or older; (2) Covered Persons who are less than 50 years of age and at a high risk for colorectal cancer; (3) Covered Persons experiencing the following symptoms: bleeding from the rectum or blood in the stool; a change in bowel habits, such as diarrhea, constipation, or narrowing of the stool, that lasts more than 5 days.
   The colorectal screening will involve an examination of the entire colon, including the following exams or laboratory tests, or both:
   1. An annual fecal occult blood test utilizing the take-home multiple sample method or an annual fecal immunochemical test in conjunction with a flexible sigmoidoscopy every 5 years;
   2. A double-contrast barium enema every 5 years; or
   3. A colonoscopy every 10 years; and
   4. Any additional medically recognized screening tests for colorectal cancer required by the Director of the Department of Health.

   Follow-up screenings are covered as follows:
   1. If the initial colonoscopy is normal, follow-up is recommended in 10 years;
   2. For Covered Persons with 1 or more neoplastic polyps, adenomatous polyps, assuming that the initial colonoscopy was complete to the cecum and adequate preparation and removal of all visualized polyps, follow-up is recommended in 3 years;
   3. If single tubular adenoma of less than 1 centimeter (4 for patients with large sessile adenomas greater than 3 centimeters) especially if removed in piecemeal fashion, follow-up is recommended in 6 months or until complete polyp removal is verified by colonoscopy.

   The following is a person is “at high risk for colorectal cancer”: An individual over 50 years of age or who faces a high risk for colorectal cancer because of: the presence of polyps on a previous colonoscopy, barium enema, or flexible sigmoidoscopy; family history of colorectal cancer in close relatives of parents, brothers, sisters, or children; genetic alterations of hereditary nonpolyposis colon cancer or familial adenomatous polyposis; personal history of colorectal cancer, ulcerative colitis, or Chron’s disease; or the presence of any appropriate recognized gene markers for colorectal cancer or other predisposing factors; and any additional or expanded definition of this term as recognized by medical science and determined by the Director of the Department of Health.

LIMITATIONS –

1. No benefits will be paid under this Rider for spinal manipulations, hot or cold pack treatment or ultra sound treatment; radiation therapy, including treatment planning; chemotherapy, including treatment planning; physical therapy; speech therapy; occupational therapy or for the rental or purchase of durable medical equipment; and

2. Benefits payable under this Rider for each Covered Person are subject to the **OUTPATIENT DOCTOR RIDER MAXIMUM BENEFIT PER CALENDAR YEAR** and **OUTPATIENT DOCTOR RIDER DEDUCTIBLE PER CALENDAR YEAR**, each shown in Your Certificate Schedule.

Coverage under this Rider expires concurrently with Your coverage under the Group Policy, unless while Your coverage under the Group Policy is still in effect, You notify ANTEX in writing to terminate coverage under this Rider or this Rider is otherwise modified, cancelled or replaced by ANTEX or the Group Policyholder in accordance with the terms of the Group Policy.

Effective Date, if other than Your Certificate Date: _____

Signed on behalf of American National Life Insurance Company of Texas at Galveston, Texas.

Secretary

RIDER SCHEDULE PAGE LANGUAGE (for use with **PPO** plans):

ANL-OPD09 (AR) – **OUTPATIENT DOCTOR RIDER**
RATE OF PAYMENT-
IN-NETWORK - (50%, 80%)
OUT–OF-NETWORK – (30%. 60%)
CALENDAR YEAR DEDUCTIBLE AMOUNT PER COVERED PERSON-
($750, $1,000, $1,500. $2,000, $2,500, $3,000, $4,000, $5,000)
RIDER MAXIMUM – ($25,000, $100,000)

RIDER SCHEDULE PAGE LANGUAGE (for use with **Indemnity** plans):

ANL-OPD09 (AR) – **OUTPATIENT DOCTOR RIDER**
RATE OF PAYMENT- (50%, 80%)
CALENDAR YEAR DEDUCTIBLE AMOUNT PER COVERED PERSON –
($750, $1,000, $1,500. $2,000, $2,500, $3,000, $4,000, $5,000)
RIDER MAXIMUM – ($25,000, $100,000)

AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS
HOME OFFICE: ONE MOODY PLAZA
GALVESTON, TEXAS

OUTPATIENT PRESCRIPTION DRUG RIDER

This Rider is made a part of the Group Policy or Certificate to which it is attached. This Rider is subject to all non-conflicting Group Policy provisions, terms, definitions and limitations. Unless otherwise indicated below, this Rider is effective on the Certificate Date.

DEFINITIONS

ANCILLARY DRUG CHARGE means a charge that is in addition to any Prescription Drug Co-payment for a Prescription Drug.

BRAND NAME DRUG means a Prescription Drug that is dispensed under the original patent of the manufacturer or original trademark name.

COINSURANCE AMOUNT – The benefit percentage that We will pay after You meet this Rider's Calendar Year Deductible Amount and Copayment Amount. You are responsible for any remaining charge.

COPAYMENT AMOUNT means the amount that must be paid at the time Prescription Drug is dispensed. For claims derived from drugs dispensed by a Non-Participating Pharmacy, the applicable Copayment Amount will be deducted from the reimbursement otherwise payable to the Covered Person.

GENERIC DRUG means a Prescription Drug that is approved by the FDA; has the same ingredients as a Brand Name Drug; and is dispensed under a different name than its Brand Name Drug equivalent.

MAIL ORDER DRUG means a drug that is ordered through the Mail Order Prescription program that is used to treat a chronic or degenerative health condition; and is ordered in quantities that exceed a 30-day supply and are not more than a 90-day supply.

NON-PARTICIPATING PHARMACY means a Pharmacy that is not a part of the Participating Pharmacy program associated with this Rider.

OUTPATIENT means a Covered Person is neither Hospital Confined nor a patient at a Same Day Surgery Facility.

PARTICIPATING PHARMACY means a Pharmacy that is a part of the Participating Pharmacy program associated with this Rider and is contracted to fill Prescription Drug orders when a Covered Person presents a valid drug card.

PHARMACY means a facility that is licensed to dispense Prescription Drugs and is not part of a Hospital or Ambulatory Surgical Center.

PRESCRIPTION DRUG means any medication or medicinal substance that the U.S. Food and Drug Administration has approved for general use. Federal or state law must require a Prescription Order before a pharmacy may dispense the drug (this means the drug is a legend drug). We consider insulin, including the syringes necessary for its injection and devices or appliances including, but not limited to, blood glucose testing devices, support garments, and bandages, when Doctor prescribed, as Prescription Drugs.

BENEFIT

Benefits are payable in accordance with all the terms and conditions of the Group Policy and this Rider for:

1. Prescription Drugs used for treatment of a Covered Person's Injury or Sickness;
2. When the Injury, Sickness, or Prescription Drug is not excluded; and
3. A Pharmacy dispenses the Prescription Drug.

PAYMENT OF BENEFITS - Once a Covered Person's Prescription Drug charges exceed this Rider's applicable Deductible Amount in a Calendar Year and the appropriate Copayment Amount has been paid, We will pay any additional Prescription Drug charges for the same Covered Person during the remainder of the Calendar Year at the applicable Coinsurance Amount shown in the Covered Person's Certificate Schedule.

Your selected Deductible Amount for this rider in shown in Your Certificate Schedule. The amount shown is for one Covered Person and must be met before benefits are payable under this Rider for the Covered Person. If more than one Covered Person is covered under this Rider, then the maximum Deductible Amount that must be met in a Calendar Year is two times the Deductible Amount and may be met collectively by all Covered Persons.

The Copayment Amount will vary depending upon whether the drug purchased is a Brand Name Drug or a Generic Drug. It will be applied each time a Prescription Drug order is filled. If coverage has been issued as a Preferred Provider Plan, then there are additional Copayment Amounts applicable to Mail Order Drugs. The table in Your Certificate Schedule shows these amounts. Where a Brand Name Drug is dispensed in lieu of its Generic Drug equivalent, the Generic Drug Copayment Amount will be charged instead of the Brand Name Drug Copayment Amount.

The Coinsurance Amount will also vary depending upon whether the drug purchased is a Brand Name Drug or a Generic Drug. The separate Generic Drug and Brand Name Drug Coinsurance Amounts are shown in Your Certificate Schedule. If the drug purchased is a Brand Name Drug that has a Generic Drug equivalent, the Coinsurance Amount will be the difference in the cost of the Generic Drug and the Brand Name Drug.

EXCEPTIONS

We do <u>not</u> cover drugs that are associated with an Injury or Sickness that We have excluded by name or description. We will <u>not</u> pay benefits under this Rider for drugs excluded under this Rider.

PAYMENT FOR A PRESCRIPTION DRUG DOES NOT MEAN WE HAVE ANY LIABILITY FOR ANY CLAIM. PRESCRIPTION BY A DOCTOR DOES NOT AUTOMATICALLY MAKE TREATMENT MEDICALLY NECESSARY.

No benefit will be paid for:

1. Any Ancillary Drug Charge included in the cost of the Prescription Drug;

2. The cost of any Prescription Drug dispensed in a quantity that exceeds a thirty-one (31) day supply unless the packaging of the manufacturer or the prescription requires a greater quantity, except 90 day Mail Order Drugs;

3. Prescription Drugs used in the treatment of primary nocturnal enuresis (bedwetting) for a Covered Person under the age of six;

4. Any drug which is taken to end pregnancy;

5. Any drug that does not require a Doctor's prescription, except prenatal vitamins a Doctor prescribes for pregnancy;

6. Prescription refills:
   (a) In excess of the number specified in the Doctor's prescription; or
   (b) Dispensed more than one year after the initial prescription date;

8. Prescription Drugs that a Doctor administers or dispenses while in his office or while a Covered Person is in a facility that provides medical care, including unit dose Prescription Drugs and any supplies;

9. Prescription Drugs that a Doctor prescribes or are otherwise used for:

    (a) Cosmetic purposes;
    (b) Treatment of hair loss;
    (c) Care, services or treatment that the Group Policy excludes;
    (d) Treatment of an Injury or Sickness that the Group Policy does not cover;
    (e) Losing weight;
    (f) Treating Acne (including Accutane);
    (g) Promoting growth (for example: growth hormone);
    (h) Treating sexual dysfunction or inadequacy; or
    (i) Facilitating smoking cessation (including any Prescription Drug containing nicotine or its derivatives);

10. Prescription Drugs that a Doctor prescribes for the treatment of mental illness, chronic fatigue syndrome or fibromyalgia;

11. Any Prescription Drug that is not consistent with the diagnosis and treatment of the Covered Person's Injury or Sickness because:
    (a) The Prescription Drug is excessive in terms of the scope, duration or intensity of scope;
    (b) The duration or intensity of Prescription Drug therapy is excessive in terms of what is needed to provide safe, adequate and appropriate care; or
    (c) The Prescription Drug is solely for the Covered Person's, Covered Person's family or Doctor's convenience; or

12. Prescription Drugs prescribed for the replacement of lost or stolen prescriptions.

Coverage under this Rider ends at the same time Your Group Policy coverage ends. However, ANTEX or the Group Policyholder may otherwise modify, cancel or replace this Rider in accordance with Group Policy terms.

While Your Group Policy coverage is still in force, You may notify ANTEX, in writing, to end coverage under this Rider.

Effective Date, if other than Your Certificate Date: _____

Signed on behalf of American National Life Insurance Company of Texas at Galveston, Texas.

Secretary

RIDER SCHEDULE PAGE LANGUAGE:

ANL-OPRx09 (AR) – OUTPATIENT PRESCRIPTION DRUG RIDER

DEDUCTIBLE AMOUNT –

INDIVIDUAL –

PARTICIPATING PHARMACY – ($500 OR $1,000)

NON-PARTICIPATING PHARMACY – ($1,000 OR $2,000)

FAMILY – TWO TIMES THE APPLICABLE INDIVIDUAL DEDUCTIBLE AMOUNT.

COPAYMENT AMOUNT –

GENERIC DRUG	BRAND NAME DRUG	MAIL ORDER GENERIC DRUG*	MAIL ORDER BRAND NAME DRUG*
$10	$25	$30	$75

***NOT AVAILABLE FROM A NON-PARTICIPATING PHARMACY.**

COINSURANCE AMOUNT –

GENERIC DRUGS – 100%

BRAND NAME DRUGS – 50% **OR**

WHEN GENERIC DRUG EQUIVALENT EXISTS – THE DIFFERENCE BETWEEN THE COST OF THE GENERIC DRUG AND THE BRAND NAME DRUG.

CONSUMER INFORMATION NOTICE

Insurer:
AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS
Home Office: One Moody Plaza, Galveston, Texas 77550
Phone Number: 1-800-899-6805

Agent:
[Name]
[Address]
[Telephone Number]

If We at American National Life Insurance Company of Texas fail to provide you with reasonable and adequate service, you should feel free to contact:

ARKANSAS INSURANCE DEPARTMENT
Consumer Services Division
1200 West Third Street
Little Rock, AR 72201-1904
Phone Number: (501) 371-2640 or (800) 852-5494

SERFF Tracking Number:	*ANTX-126249188*	*State:*	*Arkansas*
Filing Company:	*American National Life Insurance Company of Texas*	*State Tracking Number:*	*43144*
Company Tracking Number:			
TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15G.002 Large Group Only*
Product Name:	*NBA 09 AR*		
Project Name/Number:	*NBA 09 AR/*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	09/03/2009

Comments:
certifications
Attachments:
Bulletin 9-85 Certification.pdf
COMPLIANCE CERTIFICATION.pdf
CONSUMER INFORMATION NOTICE.pdf

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	09/03/2009
Bypass Reason:	applications are attached under the Forms Schedule		

Comments:

		Item Status:	Status Date:
Satisfied - Item:	Master Policy	Approved-Closed	09/03/2009

Comments:
Policy issued to the NBA, the Policyholder
Attachment:
ANL-C09-P.pdf

		Item Status:	Status Date:
Satisfied - Item:	NBA bylaws and articles of incorporation	Approved-Closed	09/03/2009

Comments:
bylaws and articles of incorporation
Attachments:

SERFF Tracking Number:	*ANTX-126249188*	*State:*	*Arkansas*
Filing Company:	*American National Life Insurance Company of Texas*	*State Tracking Number:*	*43144*
Company Tracking Number:			
TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15G.002 Large Group Only*
Product Name:	*NBA 09 AR*		
Project Name/Number:	*NBA 09 AR/*		

NBA docs Part 1a.pdf
NBA docs Part 1b.pdf
NBA docs 2a.pdf
NBA docs 2b.pdf

		Item Status:	**Status Date:**
Satisfied - Item:	Executed offers to Policyholder, the NBA	Approved-Closed	09/03/2009

Comments:
The application filled out by the individual member of the association, the NBA, is not the same application filled out by the Policyholder, the NBA.
Historically, mandated offers are separate documents from the Policyholder's application, but become part of the Policyholder application.

Attachment:
AR executed off.pdf

AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS
ONE MOODY PLAZA
GALVESTON, TEXAS 77550

I certify that benefits payable under product ANL-C09 (AR) comply with Bulletin 9-85.

William H. Watson III
Vice President, Actuary
August 3, 2009

COMPLIANCE CERTIFICATION

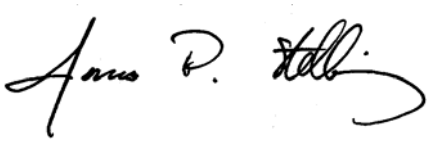
We certify that we are in compliance with the following:

- o 019 Rule and Regulation 19 - Unfair Sex Discrimination in the Sale of Insurance

- o 049 Rule and Regulation 49 - Life and Health Insurance Guaranty Association Notices –The notice is contained in all certficates issued to citizens of the state of Arkansas

- **o** Minimum standards. All forms submitted in this filing achieve a minimum score of forty (40) on the Flesch reading ease test

- o 23-79-138. Information to accompany policies – form ANL-CIN (AR) is contained in all certificates issued to residents of the state of Arkansas



James P. Stelling
Vice President

Dated: August 3, 2009

CONSUMER INFORMATION NOTICE

Insurer:
AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS
Home Office: One Moody Plaza, Galveston, Texas 77550
Phone Number: 1-800-899-6805

Agent:
[Name]
[Address]
[Telephone Number]

If We at American National Life Insurance Company of Texas fail to provide you with reasonable and adequate service, you should feel free to contact:

ARKANSAS INSURANCE DEPARTMENT
Consumer Services Division
1200 West Third Street
Little Rock, AR 72201-1904
Phone Number: (501) 371-2640 or (800) 852-5494

AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS

A Stock Life Insurance Company
HOME OFFICE: ONE MOODY PLAZA
GALVESTON, TEXAS 77550

GROUP HOSPITAL INSURANCE POLICY

We pay benefits in accordance with all the terms and conditions of this Policy for Medical Service charges that are described in the section called "Medical Services" and incurred by a Covered Person as the result of the Medically Necessary treatment of:

INJURY that occurs after his/her Certificate Date; or

SICKNESS that begins after his/her Certificate Date.

The Certificate is not the contract of insurance, however it provides evidence of coverage under this Policy. **READ IT CAREFULLY.**

IMPORTANT NOTICE CONCERNING STATEMENTS IN EACH CERTIFICATEHOLDER'S ENROLLMENT APPLICATION - Each Certificateholder should read his/her Enrollment Application and all documents attached to his/her Certificate. **Omissions or misstatements in the Enrollment Application or any attached documents may cause Us to deny an otherwise valid claim or rescind coverage.** Carefully check all documents. The Certificateholder must advise Our Underwriting Department in writing within 10 days of his/her receipt of his/her Certificate if he/she determines that any information or medical history is incomplete, incorrect, or has changed since the date of his/her Enrollment Application.

A Certificateholder's Enrollment Application and all attached documents are part of this Policy. We provide coverage described in this Policy on the basis that all of the answers to the questions and all the material information contained in the documents are correct and complete. No agent or employee, except an officer of the Company, has the authority to waive any of the requirements in the documents or waive any of the provisions of this Policy.

We do not provide coverage until we have approved an Applicant's Enrollment Application and the Initial Premium has been paid. The Initial Premium pays for the Initial Term of coverage. The Initial Term of coverage begins at 12:01 A.M., local time, at the residence of each Certificateholder on his/her Certificate Date. Coverage is continued in accordance with all of the provisions of this Policy.

10 DAY RIGHT TO EXAMINE THE CERTIFICATE – The Certificateholder may return the Certificate to Us for any reason within 10 days after he/she receives it. The Certificateholder may bring it in person or mail it to Us. At the time the Certificateholder returns the Certificate, coverage under this Policy is void from the beginning. We will refund any premium paid.

PREMIUMS ARE SUBJECT TO CHANGE - Please refer to the section titled **PREMIUMS**.

THIS POLICY – The Certificateholder may review this Policy during usual business hours at the Group Policyholder's office.

SECRETARY

PRESIDENT

THIS POLICY PROVIDES COVERAGE FOR HOSPITAL EXPENSES DESCRIBED IN THIS POLICY AND THE CERTIFICATE. WHEN SELECTED, A PREFERRED PROVIDER COMPONENT IS INCLUDED WITH THIS COVERAGE.

POLICY SCHEDULE

REMARKS - SEE ANY ATTACHED FORMS

NOTICE –

BENEFIT OPTION – A
COVERAGE – INDIVIDUAL/ FAMILY
DEDUCTIBLE AMOUNT – ($750, $1,500, $2,000, $2,500, $5,000, $10,000, $15,000, $20,000, $25,000) PER COVERED PERSON PER CALENDAR YEAR
RATE OF PAYMENT – (100%, 80%, 50%)
STOP-LOSS AMOUNT - ($5,000, $10,000)
MAXIMUM POLICY BENEFIT FOR EACH INJURY OR SICKNESS PER COVERED PERSON -- $1,000,000 ($2,000,000)

REFER TO MEDICAL SERVICES FOR A DESCRIPTION OF EXPENSES COVERED BY THE POLICY.
REFER TO EXCEPTIONS FOR A DESCRIPTION OF EXPENSES THAT ARE NOT COVERED BY THE POLICY.

GROUP POLICY NUMBER:
GROUP POLICY DATE:
GROUP POLICYHOLDER:
STATE OF ISSUE:

POLICY SCHEDULE

REMARKS - SEE ANY ATTACHED FORMS

NOTICE –

BENEFIT OPTION – A
COVERAGE – INDIVIDUAL/ FAMILY
DEDUCTIBLE AMOUNT – ($750, $1,500, $2,000, $2,500, $5,000, $10,000, $15,000, $20,000, $25,000) PER COVERED PERSON PER CALENDAR YEAR
RATE OF PAYMENT –
IN-NETWORK - (100%, 80%, 50%)
OUT-OF-NETWORK - (80% OF THE FIRST $5,000, 100% THEREAFTER)

(60% UP TO THE STOP LOSS AMOUNT, 100% THEREAFTER)

(30% UP TO THE STOP LOSS AMOUNT, 100% THEREAFTER)

STOP-LOSS AMOUNT - ($5,000, $10,000)
MAXIMUM POLICY BENEFIT FOR EACH INJURY OR SICKNESS PER COVERED PERSON -- $1,000,000 ($2,000,000)

REFER TO MEDICAL SERVICES FOR A DESCRIPTION OF EXPENSES COVERED BY THE POLICY.
REFER TO EXCEPTIONS FOR A DESCRIPTION OF EXPENSES THAT ARE NOT COVERED BY THE POLICY.

GROUP POLICY NUMBER:
GROUP POLICY DATE:
GROUP POLICYHOLDER:
STATE OF ISSUE:

POLICY SCHEDULE

REMARKS - SEE ANY ATTACHED FORMS

NOTICE –

BENEFIT OPTION – B

RATE OF PAYMENT – (100%)
DEDUCTIBLE AMOUNT – ($3,000, $4,000, $5,000, $10,000)
UNPAID MEDICAL SERVICE
CHARGE MAXIMUM - ($3,000, $4,000, $5,000, $10,000) INCLUDES DEDUCTIBLE

RATE OF PAYMENT – (80%)
DEDUCTIBLE AMOUNT – ($3,000, $4,000, $5,000, $10,000)
UNPAID MEDICAL SERVICE
CHARGE MAXIMUM - ($7,000, $8,000, $9,000, $14,000) INCLUDES DEDUCTIBLE

RATE OF PAYMENT – (50%)
DEDUCTIBLE AMOUNT – ($3,000, $4,000, $5,000, $10,000)
UNPAID MEDICAL SERVICE
CHARGE MAXIMUM - ($8,000, $9,000, $10,000, $15, 000) INCLUDES DEDUCTIBLE

MAXIMUM POLICY BENEFIT FOR EACH
INJURY OR SICKNESS PER COVERED PERSON -- $1,000,000 ($2,000,000)

REFER TO MEDICAL SERVICES FOR A DESCRIPTION OF EXPENSES COVERED BY THE POLICY.
REFER TO EXCEPTIONS FOR A DESCRIPTION OF EXPENSES THAT ARE NOT COVERED BY THE POLICY.

GROUP POLICY NUMBER:
GROUP POLICY DATE:
GROUP POLICYHOLDER:
STATE OF ISSUE:

POLICY SCHEDULE

REMARKS - SEE ANY ATTACHED FORMS

NOTICE –

BENEFIT OPTION – B

RATE OF PAYMENT –
IN-NETWORK - (100%)
OUT-OF-NETWORK - (80%)
DEDUCTIBLE AMOUNT – ($3,000, $4,000, $5,000, $10,000)
UNPAID MEDICAL SERVICE
CHARGE MAXIMUM - ($3,000, $4,000, $5,000, $10,000) INCLUDES DEDUCTIBLE

RATE OF PAYMENT –
IN-NETWORK – (80%)
OUT-OF-NETWORK - (60%)
DEDUCTIBLE AMOUNT – ($3,000, $4,000, $5,000, $10,000)
UNPAID MEDICAL SERVICE
CHARGE MAXIMUM - ($7,000, $8,000, $9,000, $14,000) INCLUDES DEDUCTIBLE

RATE OF PAYMENT –
IN-NETWORK - (50%)
OUT-OF-NETWORK - (30%)
DEDUCTIBLE AMOUNT – ($3,000, $4,000, $5,000, $10,000)
UNPAID MEDICAL SERVICE
CHARGE MAXIMUM - ($8,000, $9,000, $10,000, $15, 000) INCLUDES DEDUCTIBLE

MAXIMUM POLICY BENEFIT FOR EACH
INJURY OR SICKNESS PER COVERED PERSON -- $1,000,000 ($2,000,000)

REFER TO MEDICAL SERVICES FOR A DESCRIPTION OF EXPENSES COVERED BY THE POLICY.
REFER TO EXCEPTIONS FOR A DESCRIPTION OF EXPENSES THAT ARE NOT COVERED BY THE POLICY.

GROUP POLICY NUMBER:
GROUP POLICY DATE:
GROUP POLICYHOLDER:
STATE OF ISSUE:

POLICY SCHEDULE

REMARKS - SEE ANY ATTACHED FORMS

THE PLAN DEDUCTIBLE AND UNPAID MEDICAL SERVICES MAXIMUM WILL CHANGE IN ACCORDANCE WITH FEDERAL REQUIREMENTS.

NOTICE –

COVERAGE – (INDIVIDUAL/ FAMILY**)**
BENEFIT OPTION – NOT APPLICABLE
RATE OF PAYMENT – (100%)
DEDUCTIBLE AMOUNT –
INDIVIDUAL - ($1,500, $2,000, $2,500, $5,000)
FAMILY - ($3,000, $4,000, $5,000, $10,000)
UNPAID MEDICAL SERVICE
CHARGE MAXIMUM - INDIVIDUAL - ($1,500, $2,000, $2,500, $5,000) INCLUDES DEDUCTIBLE
FAMILY - ($3,000, $4,000, $5,000, $10,000) INCLUDES DEDUCTIBLE

RATE OF PAYMENT – (80%)
DEDUCTIBLE AMOUNT –
INDIVIDUAL - ($1,500, $2,000, $2,500)
FAMILY - ($3,000, $4,000, $5,000)
UNPAID MEDICAL SERVICE
CHARGE MAXIMUM - INDIVIDUAL - ($3,500, $4,000, $4,500) INCLUDES DEDUCTIBLE
FAMILY - ($7,000, $8,000, $9,000) INCLUDES DEDUCTIBLE

RATE OF PAYMENT – (50%)
DEDUCTIBLE AMOUNT –
INDIVIDUAL - ($1,500, $2,000, $2,500)
FAMILY - ($3,000, $4,000, $5,000)
UNPAID MEDICAL SERVICE
CHARGE MAXIMUM - INDIVIDUAL - ($4,000, $4,500, $5,000) INCLUDES DEDUCTIBLE
FAMILY - ($8,000, $9,000, $10,000) INCLUDES DEDUCTIBLE

MAXIMUM POLICY BENEFIT FOR EACH
INJURY OR SICKNESS PER COVERED PERSON -- $1,000,000 ($2,000,000)

REFER TO MEDICAL SERVICES FOR A DESCRIPTION OF EXPENSES COVERED BY THE POLICY.
REFER TO EXCEPTIONS FOR A DESCRIPTION OF EXPENSES THAT ARE NOT COVERED BY THE POLICY.

GROUP POLICY NUMBER:
GROUP POLICY DATE:
GROUP POLICYHOLDER:
STATE OF ISSUE:

POLICY SCHEDULE

REMARKS - SEE ANY ATTACHED FORMS
THE PLAN DEDUCTIBLE AND UNPAID MEDICAL SERVICES MAXIMUM WILL CHANGE IN ACCORDANCE WITH FEDERAL REQUIREMENTS.

NOTICE –**OUT-OF-NETWORK PENALTY –** COVERAGE UNDER THE POLICY INCLUDES A PPO COMPONENT. THE CERTIFICATEHOLDER IS ENCOURAGED TO USE AN IN-NETWORK PROVIDER TO RECEIVE THE MAXIMUM AMOUNT PAYABLE FOR ELIGIBLE MEDICAL SERVICE CHARGES. USE OF AN OUT-OFNETWORK PROVIDER RESULTS IN A 20% REDUCTION OF ANY OTHERWISE ELIGIBLE MEDICAL SERVICE CHARGE THAT WE DO NOT PAY DUE TO A COVERED PERSON'S VOLUNTARY USE OF AN OUT-OF-NETWORK PROVIDER.

COVERAGE – (INDIVIDUAL/ FAMILY**)**
BENEFIT OPTION – NOT APPLICABLE
RATE OF PAYMENT – (100%)
DEDUCTIBLE AMOUNT –
INDIVIDUAL - ($1,500, $2,000, $2,500, $5,000)
FAMILY - ($3,000, $4,000, $5,000, $10,000)
UNPAID MEDICAL SERVICE CHARGE MAXIMUM - **INDIVIDUAL** - ($1,500, $2,000, $2,500, $5,000) INCLUDES DEDUCTIBLE
FAMILY - ($3,000, $4,000, $5,000, $10,000) INCLUDES DEDUCTIBLE

RATE OF PAYMENT – (80%)
DEDUCTIBLE AMOUNT –
INDIVIDUAL - ($1,500, $2,000, $2,500)
FAMILY - ($3,000, $4,000, $5,000)
UNPAID MEDICAL SERVICE CHARGE MAXIMUM - **INDIVIDUAL** - ($3,500, $4,000, $4,500) INCLUDES DEDUCTIBLE
FAMILY - ($7,000, $8,000, $9,000) INCLUDES DEDUCTIBLE

RATE OF PAYMENT – (50%)
DEDUCTIBLE AMOUNT –
INDIVIDUAL - ($1,500, $2,000, $2,500)
FAMILY - ($3,000, $4,000, $5,000)
UNPAID MEDICAL SERVICE CHARGE MAXIMUM - **INDIVIDUAL** - ($4,000, $4,500, $5,000) INCLUDES DEDUCTIBLE
FAMILY - ($8,000, $9,000, $10,000) INCLUDES DEDUCTIBLE

MAXIMUM POLICY BENEFIT FOR EACH INJURY OR SICKNESS PER COVERED PERSON -- $1,000,000 ($2,000,000)

REFER TO MEDICAL SERVICES FOR A DESCRIPTION OF EXPENSES COVERED BY THE POLICY.
REFER TO EXCEPTIONS FOR A DESCRIPTION OF EXPENSES THAT ARE NOT COVERED BY THE POLICY.

GROUP POLICY NUMBER:
GROUP POLICY DATE:
GROUP POLICYHOLDER:
STATE OF ISSUE:

TABLE OF CONTENTS

PREMIUMS

Premiums are due on the first day of each term that follows the Initial Term. This is called the Premium Due Date. The required premium will depend on the Certificateholder's premium class. We determine the premium class on each Premium Due Date. We will NOT CHANGE the Certificateholder's premium prior to the first anniversary of his/her Certificate Date, unless:

1. Coverage changes; or
2. Residence changes.

After the first anniversary of the Certificateholder's coverage, We will change premiums:

1. Annually, based on attained age;
2. When the Certificateholder moves to a different rating zone; or
3. Anytime, and from time to time, that We decide to change rates for persons in the Certificateholder's or a Covered Person's class.

Changes will apply to premiums due on or after the effective date of the change. The new rates will apply on a class basis as determined by Us. We will give the Certificateholder 30 days notice before any premium change.

WAIVER OF PREMIUM - If the Certificateholder dies, We will waive premiums for remaining Covered Persons for 12 months beginning with the next Premium Due Date following Our receipt of due proof of the Certificateholder's death. During this premium waiver period no increases in benefits or addition of Covered Persons, except newborns, will be considered. All provisions for Loss of Eligibility for Covered Persons will remain applicable during this premium waiver period.

At the end of the 12 months during which premiums were waived, coverage may be continued for Covered Persons by resuming payment of the required premium.

DEFINITIONS

AMBULANCE means a motor vehicle, helicopter, or fixed wing aircraft specially equipped to transport Sick and Injured people. A common carrier is not an Ambulance.

CALENDAR YEAR means the twelve-month period that begins January 1 and ends December 31, each year.

CERTIFICATE means the written description of coverage provided to the Certificateholder as evidence of coverage under this Policy.

CERTIFICATE DATE means the date, shown in the Certificate Schedule, when coverage begins for the Covered Persons originally covered under this Policy. We use the Certificate Date to determine the anniversary dates of coverage under this Policy. It also refers, separately, to the date We add a Covered Person to this Policy or when any change in coverage occurs.

CERTIFICATEHOLDER means the Applicant named in the Enrollment Application or any successor thereof named to assume ownership privileges under this Policy. Such person, regardless of title, has exclusive ownership privileges under this Policy. These privileges include, but are not limited to, his/her right to change coverage under this Policy for themselves or any Covered Person.

CLOSE RELATIVE means the Certificateholder or anyone related to him by blood, marriage, or adoption; or a court appointed representative.

COMPLICATIONS OF PREGNANCY means either of these two general types of conditions:

1. **TYPE I CONDITIONS:** The pregnancy does not end. The cause of the complication is distinct from the pregnancy. Examples include acute nephritis, nephrosis, and cardiac decompensation. There may be other similar conditions as well.

2. **TYPE II CONDITIONS**: The pregnancy ends. Any of the following may occur: delivery by Medically Necessary Cesarean section, ending of ectopic pregnancy, or spontaneous ending of pregnancy that takes place when a live birth is not possible.

THE FOLLOWING CONDITIONS ARE NOT COMPLICATIONS OF PREGNANCY: false labor; pre-term or premature labor; occasional spotting; prescribed rest while pregnant; morning sickness; hyperemesis gravidarum; or pre-eclampsia. There may be other conditions that relate to a difficult pregnancy that a Doctor can manage. We will not consider such a condition as a Complication of Pregnancy.

COVERED PERSON means each person named as a Covered Person on the Certificate Schedule whose coverage under the Group Policy has not terminated.

DOCTOR means a person, other than the Certificateholder or a Close Relative, who is duly licensed to provide the type of medical treatment for which benefits are provided under this Policy, and acting within the scope of that license.

EMERGENCY means a medical condition of recent onset and sufficient severity to cause a prudent person to believe that without immediate medical attention the condition may result in:

1. Placing the patient's health in serious jeopardy;
2. Serious impairment to bodily functions;
3. Serious dysfunction of any bodily organ or part;
4. Serious disfigurement; or
5. In the case of a pregnant woman, serious jeopardy to the health of the fetus.

EXPERIMENTAL OR INVESTIGATIONAL MEDICINE means any of the following (generally, individually or collectively, called Regimen) that, when used to treat a Covered Person's specific Injury or Sickness, are experimental, investigational or oriented toward research:

1. Equipment;
2. Drugs or dosages;
3. Devices, services, supplies, tests or medical treatment or procedures; or
4. All related treatment and procedures.

We consider a Regimen as **EXPERIMENTAL OR INVESTIGATIONAL MEDICINE** if:

1. The U.S. Food and Drug Administration (FDA) has not given final approval to the Regimen for the lawful marketing for the treatment of the specific Injury or Sickness; or
2. The American Medical Association (AMA) has not approved or endorsed the Regimen for the treatment of the specific Injury or Sickness; or
3. The National Institutes of Health (NIH) or its affiliated institutes have not approved or endorsed the Regimen for the treatment of the specific Injury or Sickness; or
4. The Regimen is:

   a) Currently used or will be used or studied in proposed or ongoing clinical research or clinical trials as evidenced by the Informed Consent or investigational protocol; or
   b) Part of a proposed or ongoing phase I, II or III clinical trial; or
   c) Subject of proposed or ongoing research or studies to determine its dosage, safety, toxicity, efficacy, or its efficacy as compared to other means of treatment or diagnosis; or

5. The opinion of medical or scientific experts indicates that further studies, research or clinical trials are necessary to determine the Regimen's dosage, safety, toxicity, efficacy or its efficacy as compared to other means of treatment or diagnosis. The opinion of medical or scientific experts is as reflected in:

   a) Published reports or articles in medical or scientific literature; or
   b) Written protocol(s) used by the treating facility or other facilities studying the same or substantially similar Drugs, devices, services, supplies, tests, treatments, or procedures; or
   c) The Informed Consent used by the treating facility or other facilities studying the same or substantially similar Drugs, devices, services, supplies, tests, treatments, or procedures.

We will not exclude a drug for the treatment of cancer because the FDA has not approved the drug for the treatment of the specific type of cancer for which a Doctor has prescribed the drug. However, standard reference compendia or medical literature must recognize the drug for treatment of that specific type of cancer. We will not cover a drug:

1. That the FDA has not approved; or
2. The FDA has contraindicated its use.

HOME HEALTH CARE PLAN means that a licensed Home Health Care Agency provides care and treatment for an Injury or Sickness at a Covered Person's residence. A Doctor must set up and approve a plan in writing.

HOSPICE means an alternative way of caring for terminally ill individuals provided by an entity licensed to provide hospice care for terminally ill individuals and his/her Immediate Families.

HOSPITAL means a facility that:
1. Is licensed as a Hospital in the jurisdiction where it operates; and
2. Provides medical and surgical services for the treatment of Injury or Sickness under the supervision of a Doctor.

The term "Hospital" does not include:

1. A convalescent, nursing, rest or rehabilitative facility; a home for the aged; a special ward, floor or other accommodation for convalescent, skilled nursing, rehabilitation, ambulatory or extended care purposes, including the separate section of a building that houses an acute care facility; hotel units, residential annexes, nurse administered units in or associated with a Hospital; or a psychiatric/substance abuse facility.

2. Any military or veteran's Hospital, soldier's home or any Hospital contracted for or operated by the Federal Government or any agencies thereof for the treatment of members or former members of the Armed Forces, unless the Covered Person is legally required to pay for services in the absence of coverage under the Group Policy.

HOSPITAL CONFINED means that a Covered Person is admitted to a Hospital as an overnight resident bed patient. "Hospital Confined" does not include a Covered Person's treatment in a Same Day Surgery facility, Emergency room, or an observation room.

INJURY (Injured) means accidental bodily injury sustained by the Covered Person, which is the direct cause of loss, independent of disease, bodily infirmity, or any other cause which occurs while coverage under this Policy is in force.

INTENSIVE CARE UNIT, CORONARY CARE UNIT OR NEONATAL INTENSIVE CARE UNIT means that part of a Hospital specifically designed as an intensive care unit that is permanently equipped and staffed to provide more extensive care for critically ill or Injured patients than is available in other Hospital rooms or wards. Services provided include close observation by trained and qualified personnel whose duties are primarily confined to the part of the Hospital for which an additional charge is made.

LIMITING AGE for the Certificateholder's children is attained age 26. This is the Certificateholder's coverage anniversary next following the child's 26th birthday.

MEDICALLY NECESSARY means a service or supply necessary and appropriate for the diagnosis or treatment of an Injury or Sickness based upon current generally accepted medical practices. The fact that a Doctor may prescribe, order, recommend, or approve a service or supply does not, of itself, make the service or supply Medically Necessary. A service or supply is not Medically Necessary if:

1. It is provided only as a convenience to the Covered Person or provider;
2. It is not appropriate treatment for the Covered Person's diagnosis or symptoms;
3. It exceeds (in scope, duration, or intensity) that level of care that is needed to provide safe, adequate, and appropriate diagnosis or treatment; or
4. It is Experimental or Investigational Medicine.

MEDICARE means a United States government program set up to provide health care benefits. Medicare includes:

1. The program under Title XVIII of Social Security with any later changes; or
2. Similar programs meant to pay for health care.

MEDICINES OR DRUGS means any medication or medicinal substance that the U.S. Food and Drug Administration has approved for use. The Medicines or Drugs must be used in the Hospital.

MENTAL DISORDER means a disease or disorder, regardless of its cause, that affects the mind or behavior. Categories of mental disorders include mood disorders, anxiety disorders, psychotic disorders, eating disorders, developmental disorders, personality disorders, and other generally accepted disorders of a similar type.

NURSE means any of these:

1. Licensed Registered Nurse (R.N.);
2. Licensed Practical Nurse (L.P.N.);
3. Licensed Vocational Nurse (L.V.N.); or
4. Nurse Practitioner.

"Nurse" does not include a Covered Person or any Close Relative.

ORGAN TRANSPLANT means the placement of tissue or an organ from a live or cadaver donor in a Covered Person. This includes tissue, organ, or cells harvested and returned to the same person, where such tissue or organ is somewhat independent from all other parts of the human body and performs a special or unique function. The source of the tissue, organ, or cells may be from another person. An Organ Transplant does not include the placement of a mechanical or man-made device or substance when the device or substance:

1. Is intended to serve as a substitute for the tissue or organ; or
2. Aids in the performance of the tissue or organ.

An Organ Transplant does not include the grafting of solid tissue or organ such as bone or skin.

PREEXISTING CONDITION for each Covered Person means a condition not otherwise excluded by name or specific description: (1) for which medical advice, testing, care, treatment or medication was given or was recommended by, or received from, a Doctor within 12 months before the Certificate Date; or (2) that would have caused a reasonably prudent person to seek medical diagnosis or treatment within 12 months before such Covered Person's Certificate Date. The Company does not cover Pre-Existing Conditions for the first 12 months of coverage.

REASONABLE AND CUSTOMARY CHARGES means the dollar amount charged that is the lesser of:

1. The actual dollar amount charged;
2. The dollar amount usually charged for the service by the provider who furnishes it; or
3. The prevailing dollar amount charge made for a service in a geographical area made by a facility or person.

SAME DAY SURGERY FACILITY means a licensed medical facility or a part of a Hospital:

1. With an organized staff of Doctors;
2. That is permanently equipped and operated primarily for the purpose of performing surgical procedures;
3. That does not provide accommodations for overnight stays; and
4. That provides continuous Doctor services and nursing services whenever a patient is in the facility.

The term "Same Day Surgery Facility" does not include a:

1. Hospital Emergency room;
2. Trauma center; or
3. Doctor's office or Clinic.

SICKNESS means a Covered Person's illness, disease, or condition that begins after the Certificate Date and while the Covered Person has coverage under this Policy. Sickness also includes an illness, disease or condition that begins before the Certificate Date if it is shown on the Enrollment Application and We have not excluded it from coverage by name or specific description. Sickness includes any complications or recurrences that relate to such Sickness while this Policy's coverage is in effect for the Covered Person.

US, WE, OUR or THE COMPANY means American National Life Insurance Company of Texas (ANTEX).

YOU or YOUR means the Certificateholder.

BENEFITS

WHAT WE PAY – Benefits are payable under this Policy in accordance with Benefit Option A or Benefit Option B, each described below. Each Certificateholder's selected Benefit Option is shown in the Certificateholder's Certificate Schedule. The Benefit Option in effect on January 1st of each year will remain in effect for the remainder of the same Calendar Year. Benefits will not be paid under more than one benefit option during a Calendar Year. All benefits payable under this Policy are subject to this Policy's Maximum Policy Benefit for each Injury or Sickness per Covered Person. A Covered Person's selected Deductible Amount, Rate of Payment, and Stop Loss Amount are each shown in his/her Certificate Schedule.

BENEFIT OPTION A - Benefits are payable under this Policy after a Covered Person incurs charges during a Calendar Year for Medical Services in excess of his/her Deductible Amount. Benefits will be paid at the Rate of Payment. If Your selected Rate of Payment is less than 100%, once charges for Medical Services exceed the Stop-Loss Amount shown in the Certificate Schedule during a Calendar Year, the Rate of Payment for the remainder of the Calendar Year is 100%.

BENEFIT OPTION B - Benefits are payable under this Policy after combined charges for Medical Services incurred by one or more Covered Persons during a Calendar Year exceed the Deductible Amount. Benefits will be paid at the Rate of Payment. If Your selected Rate of Payment is less than 100%, once combined unpaid charges for Medical Services incurred by one or more Covered Persons during a Calendar Year exceed the Unpaid Medical Service Charge Maximum shown in the Certificateholder's Certificate Schedule, the Rate of Payment for the remainder of the Calendar Year is 100%. In the event coverage under this Benefit Option B is provided for only one Covered Person, the Deductible Amount shown in Your Certificate Schedule will be reduced by 50%.

UNPAID MEDICAL SERVICES MAXIMUM – This is the maximum amount that You pay each Calendar Year comprised of charges for Medical Services applied to the Deductible Amount and Rate of Payment for Medical Services before We pay 100% of Medical Services charges. There is an Individual or a Family Unpaid Medical Services Maximum depending on whether family coverage is provided. Once Covered Persons have met the Family Unpaid Medical Services Maximum, individually or collectively, We will pay 100% of charges for Medical Services for all Covered Persons for the remainder of the Calendar Year. The Policy Schedule shows Unpaid Medical Services Maximum. **We <u>do not</u> apply the following toward the Unpaid Medical Services Maximum: any non-Medical Service charge, or ineligible expense.**

POLICY MAXIMUM FOR EACH INJURY OR SICKNESS is shown in each Certificateholder's Certificate Schedule. This Maximum applies to each Covered Person.

THE FOLLOWING PROVISIONS DO <u>NOT</u> APPLY IF BENEFIT OPTION B IS IN EFFECT.

FAMILY DEDUCTIBLE MAXIMUM – Once three family members have met their respective Deductible Amounts in a Calendar Year, no further Deductible Amount will be required for the remainder of the Calendar Year.

COMMON ACCIDENT DEDUCTIBLE – If two or more Covered Persons incur Medical Service charges from Injuries sustained in a single accident, We will apply the lesser of:

1. The Deductible Amount;
2. The remainder of each Covered Person's respective Deductible Amount; or
3. The remainder of the Family Deductible Maximum.

VANISHING DEDUCTIBLE AMOUNT – This provision does not apply to a Deductible Amount in excess of $15,000. If coverage under the Group Policy is in effect for a complete Calendar Year and We do not pay any benefits on behalf of any Covered Person, We will reduce the Cash Deductible Amount for the following Calendar Year by 25%. However, We will give no further reductions after the Cash Deductible Amount is reduced to zero. If We pay benefits on behalf of any Covered Person during a Calendar Year, the Cash Deductible Amount for all Covered Persons for the next Calendar Year is the amount shown on the Certificate Schedule. We will extend this provision to any Covered Person added during a Calendar Year during which the Cash Deductible Amount has been reduced.

MEDICAL SERVICES

WE PAY BENEFITS FOR REASONABLE AND CUSTOMARY CHARGES INCURRED FOR THE FOLLOWING MEDICAL SERVICES AT THE APPLICABLE RATE OF PAYMENT. Benefits payable for Medical Services are subject to all terms, limits, and conditions of this Policy.

An expense is "incurred" on the date a provider renders the service or furnishes the supplies.

The following are Medical Services under this Policy :

Professional Ambulance Service (air or ground) – Reasonable and Customary Charges for transportation to the nearest Hospital qualified to provide for the Covered Person's Medically Necessary Emergency treatment.

Hospital Stay - The Hospital charge for each day a Covered Person is Hospital Confined. Such charge will include those for:

1. Semi-private room confinement, excluding any separate charges such as room, nursing services, maintenance, utilities, and similar items;
2. Intensive Care Unit, Burn Unit, Coronary Care Unit, and Neonatal Intensive Care Unit confinement, up to three times the Hospital's average semi-private room rate; and
3. Medically Necessary miscellaneous services and supplies used for the treatment of the Hospital Confined Covered Person.

Services **DO NOT** include: charges for take-home medicines or drugs, personal or convenience items, or items that are not intended primarily for use while Hospital Confined.

Doctor Visits - Reasonable and Customary Charges for the Covered Person's Doctors' (other than the surgeon) visits when Hospital Confined. For purposes of this provision, a Doctor's consultation is a visit.

Surgery - Reasonable and Customary Charges made by an operating surgeon. If two or more surgeries are performed through the same incision, We will pay the one providing the greatest benefit under the Group Policy. We will also pay [50%] of the benefits otherwise payable for the other surgeries performed through separate incisions during the same operative session. Charges must be incurred while a Covered Person is Hospital Confined or in a Same Day Surgery Facility.

Same Day Surgery Facility - Reasonable and Customary Charges for services provided for a Covered Person by a Same Day Surgery Facility on the day surgery is performed.

If a Covered Person is retained in the Same Day Surgery Facility for more than 18 hours, charges for use of such facility will be limited to the average semi-private room rate consistent with Reasonable and Customary Charges for Hospitals in the area where the Same Day Surgery Facility is located.

Assistant Surgeon - Actual charges for services provided during a surgical procedure by an Assistant Surgeon, up to 25% of the Reasonable and Customary Charge of the primary surgeon. Charges must be incurred while a Covered Person is Hospital Confined or in a Same Day Surgery Facility.

Second Surgical Opinion - Reasonable and Customary Charges for a Doctor providing a second surgical opinion regarding the recommendation for surgery. If the initial and second surgical opinions conflict, We will pay benefits for a third surgical opinion. The Deductible Amount does not apply to a second or third opinion.

Anesthesia Administration - Reasonable and Customary Charges for the administration of anesthesia by an anesthesiologist to a Covered Person undergoing surgery while Hospital Confined or in a Same Day Surgery Facility. The anesthesiologist must be at the operation solely to provide the anesthesia service.

We will reduce benefits otherwise payable had an anesthesiologist administered anesthesia by [50%] if a nurse anesthetist, operating Doctor, or assistant Surgeon administers the anesthesia, including any incidental fluids, as part of a covered surgical procedure. When both an anesthesiologist and a nurse anesthetist bill for the same operative session, benefits will be limited to the Reasonable and Customary charges otherwise payable had the anesthesiologist been the sole provider of such services.

Breast Reconstruction - Reasonable and Customary Charges for the following services and supplies incident to mastectomy:

1. Reconstruction of the affected breast;
2. Reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and physical complications of all stages of mastectomy, including lymphedemas.

Benefits under this coverage will be subject to all the terms and conditions of this Policy, except any Exception relating to cosmetic surgery.

Pathology - Reasonable and Customary Charges for pathology services while the Covered Person is Hospital Confined or in a Same Day Surgery Facility. Professional services relating to automated pathology tests are <u>not</u> covered.

Radiology - Reasonable and Customary Charges for radiology services provided for a Covered Person while Hospital Confined or in a Same Day Surgery Facility.

Chemotherapy – Reasonable and Customary Charges for chemotherapy.

Physiotherapy - Reasonable and Customary Charges for physical, speech, occupational, or inhalation therapy. Such therapy must be provided by a Hospital based therapy facility and must result from a Covered Person's treatment in a Hospital or Same Day Surgery Facility.

Radiation Therapy – Reasonable and Customary Charges for radiation therapy.

Home Health Care - Reasonable and Customary Charges for Home Health Care, up to [$7,500] per Calendar Year when a Covered Person receives Home Health Care. The Home Health Care must:

1. Begin within 7 days of a prior Hospital Stay of at least 3 days;
2. Be provided in lieu of a Hospital Stay;
3. Be for services related to the treatment of the same Sickness or Injury for which the Covered Person was Hospital Confined; and
4. Be administered under a Home Health Care Plan.

Hospice Care Benefit - Reasonable and Customary Charges for Hospice Care provided by a licensed Hospice agency. We will not pay benefits under this provision and under another benefit provision of this Policy. We only pay benefits for Hospice Care when the Covered Person's Doctor certifies that the Covered Person's life expectancy is less than six months.

Mammogram - Reasonable and Customary Charges in excess of a Covered Person's payment of [$25] for one mammogram per Calendar Year. We pay the benefit whether or not the Covered Person is Hospital Confined. We do not apply such payment to the Deductible Amount or the Rate of Payment.

Foreign Emergency Treatment
We will pay for benefits for Medical Services resulting from charges for Emergency treatment that a Covered Person receives in a foreign country. Benefits payable will be the lesser of: (1) the actual charges for the services; or (2) the benefit for Medical Services that We would have paid if the Covered Person had received the Emergency treatment in the location where the Covered Person resides.

Complications of Pregnancy

If a Covered Person has Complications of Pregnancy while covered under this Policy, Medical Services incurred for treatment of such Complications of Pregnancy will be considered for payment as if they had resulted from Sickness. If an expense does not result solely from the treatment of the Complications of Pregnancy, then it will be deemed due to normal pregnancy and not covered under this Policy.

Organ Transplant Donor Charges - We will pay donor benefits for covered Organ Transplants:

1. Up to [$15,000] in Medical Services; if
2. The Certificateholder or a Covered Person is legally responsible for the charges.

EXCEPTIONS

WE DO NOT COVER AN INJURY OR SICKNESS THAT IS EXCLUDED BY NAME OR DESCRIPTION.

THIS POLICY DOES NOT PROVIDE COVERAGE FOR LOSS CAUSED BY, CONTRIBUTED TO, OR RESULTING FROM ANY OF THE FOLLOWING EXCEPTIONS:

1. Injury or Sickness if the loss is covered under these or similar laws:
   worker's compensation,
   employer's liability, or
   occupational disease laws.

2. Injury or Sickness that results from war or an act of war, whether war is declared or not.

3. Care or supplies that a Covered Person receives in a Hospital or other facility that a government agency runs; however, We will not apply this Exception if:

   a) The Covered Person receives a charge that he/she has to pay by law, and
   b) The Hospital or facility would have made the charge even if no insurance existed.

4. The diagnosis and/or treatment of the adenoids, tonsils, gallbladder, reproductive organs, and hernia for the first six months of coverage; however, if We have excluded any one of these conditions by rider, We do not pay any benefit for the condition, regardless of when the treatment takes place; or if such condition is a Preexisting Condition, any benefit consideration will be in accordance with the Preexisting Conditions provision; however, this Exception does not apply to a HIPAA Eligible Individual.

5. Procedures or treatments that are Experimental or Investigational Medicine.

6. Pregnancy and childbirth, except for Complications of Pregnancy.

7. Mental Disorders.

8. Cosmetic surgery however, this Exception does not apply when surgery is required:
   a) To correct damage that results from a covered Injury;
   b) To repair a birth defect of a child born to the Certificateholder and continuously covered under this Policy from its birth; or
   c) For breast reconstruction following a covered mastectomy.

9. Breast reduction and surgery to repair, replace, or remove breast implants;

10. Dental Treatment, unless due to Injury to a Covered Person's natural teeth.

11. A Pre-Existing Condition as defined in this Policy.

12. Any attempt at suicide, while sane.

13. An intentionally self-inflicted Injury, while sane.

14. A Covered Person's commission of or attempt to commit a felony, an illegal act, or being engaged in an illegal occupation.

15. A Covered Person being intoxicated, unless such intoxication is the result of a prescription drug taken as prescribed by a Doctor.

16. A Covered Person with a blood alcohol concentration equal to or in excess of .08 gms/dl operating any motor vehicle, including any off-road vehicle, or watercraft.

17. Any procedure for refractive correction, eye refraction or the purchase or fitting of vision or hearing aids, Cochlear Implants and related devices.

18. Weight reduction or treatment of obesity, including exogenous, endogenous, or morbid obesity.

19. Mandibular or maxillofacial surgery to correct growth defects and jaw disproportions or malocclusions; increase vertical dimension; or reconstruct occlusion after one year from a child's date of birth or a child's date of adoption, except where such surgery is for the repair of a congenital anomaly or birth defect of a child born to the Certificateholder or a child that he/she adopts if the child is continuously covered from birth, adoption, or placement for adoption.

20. Treatment provided outside the United States of America, its possessions and territories, except as otherwise provided under Foreign Emergency Treatment.

21. Diagnosis or treatment (including surgery) of sexual dysfunction disorder or inadequacy; or transsexual surgery.

22. Sclerotherapy for veins of the extremities or laser surgery to minimize veins.

23. Routine newborn care.

24. Care in a nursing home or custodial institution; domiciliary care or rest cures.

25. Charges for Medical Services that the Certificateholder or a Covered Person is not legally obligated to pay.

26. Any charges for or relating to: artificial insemination; in-vitro fertilization or any other diagnosis or treatment for the control, promotion, or enhancement of fertility; treatment for impotency; sterilization or reversal of prior sterilization; abortion, unless the life of the mother would be endangered if the fetus were carried to term; or therapeutic abortion.

27. Drugs and supplies provided for home use.

28. Treatment of alcoholism or drug use.

29. False labor; pre-term or premature labor; occasional spotting; prescribed rest while pregnant; morning sickness; hyperemesis gravidarum; or pre-eclampsia. There may be other conditions that relate to a difficult pregnancy that a Doctor can manage.

AUTOMATIC COVERAGE OF NEWBORN AND ADOPTED CHILDREN

A child born to or adopted by the Certificateholder will become a Covered Person under this Policy. For a child born to the Certificateholder, coverage begins on the date of birth. For a child adopted by the Certificateholder, coverage begins: (a) from the date of birth if a petition for adoption is filed within 30 days of the birth of such child; or (b) from the date of placement for the purpose of adoption if a petition for adoption is filed within 30 days of placement of the child. This coverage will be free, without action by the Certificateholder, but it will last only through the 31st day following the child's date of birth or date of adoption, as described under situation (a) or (b) above, whichever is applicable. The term "placement" means in the physical custody of the adoptive parent.

To continue the child as a Covered Person, the Certificateholder must:

1. Notify ANTEX in writing of the child's birth or date of adoption as described in (a) or (b), above; and
2. Pay the extra premium for the child no later than 62 days following the child's date of birth or date of adoption, as described in (a) or (b), above.

As long as the Certificateholder pays the extra premium, the child will remain a Covered Person, subject to the Termination of Coverage and Loss of Coverage Eligibility provisions of this Policy. Coverage for a child that is placed with the Certificateholder for adoption will continue in accordance with the Termination of Coverage and Loss of Coverage Eligibility provisions, unless the placement is disrupted prior to legal adoption and the child is removed from placement.

We do not require an application for the child unless the Certificateholder has notified Us of the child later than the 31 days as required above.

TERMINATION OF COVERAGE

We can terminate coverage under this Policy as of any premium due date under any of the following conditions:

1. The Certificateholder has failed to pay premiums or contributions in accordance with the terms of this Policy, or We have not received timely premium payments;
2. The Certificateholder or a Covered Person has performed an act or practice that constitutes fraud with respect to activities under this Policy;
3. The Certificateholder no longer resides, lives, or works in the PPO service area or in an area where We have authority to do business. We will only apply this provisions if We end coverage uniformly and without regard to any health status related factor of a Covered Person; or
4. We are ceasing to offer coverage in the medical expense market in accordance with applicable state law.

Notice of termination will be provided in accordance with state law.

Subject to the conditions listed above, We cannot refuse to renew coverage:

1. Just because of a change in a Covered Person's health or the type of work the Covered Person performs; or
2. Just because of the claims filed by or on behalf of a Covered Person, unless the claims are fraudulent.

LOSS OF ELIGIBILITY

Eligibility for continuation of coverage under this Policy by a Covered Person ends on the date of the month that coincides with the date of the month shown on the Certificate Schedule and occurs on such date next following the date of the event that causes such termination.

RULES FOR ALL COVERED PERSONS - Coverage will end:

1. If this Policy is terminated in accordance with the section titled TERMINATION OF COVERAGE; or
2. If the Certificateholder fails to pay the required premium within the Grace Period.

RULES FOR ADULT COVERED PERSONS - Coverage will end:

1. For the Certificateholder's spouse if there is a divorce; or
2. If a mentally or physically disabled Covered Person marries or becomes capable of self-support. (See the section titled EXTENSION OF COVERAGE FOR SOME CHILDREN).

RULES FOR CHILD COVERED PERSONS - Coverage will end for a child when:

1. The child is no longer a dependent of the Certificateholder;
2. The child gets married; or

3. The child attains the Limiting Age, except for the extension allowed by the section titled EXTENSION OF COVERAGE FOR SOME CHILDREN.

PREMIUM – We will adjust premiums if required under Our rules as of the date coverage ends for a Covered Person. This will occur on a date consistent with the date coverage ends, as described above.

SUCCESSION – If the Certificateholder dies and is survived by other Covered Persons, a new Certificateholder will be named in accordance with the following:

1. If the deceased Certificateholder was married at the time of death and his/her spouse is a Covered Person, the spouse will become the new Certificateholder;

2. If the deceased Certificateholder was married at the time of death and his/her spouse is not a Covered Person, while other Covered Persons survive the deceased Certificateholder, the spouse will become the Certificateholder; or

3. If the deceased Certificateholder was unmarried at the time of death while other Covered Persons survive the deceased Certificateholder, the estate of the deceased Certificateholder shall be entitled to name a new Certificateholder in accordance with the Company's rules in effect on the date of the deceased Certificateholder's death.

EXTENSION OF COVERAGE FOR SOME CHILDREN

When a dependent child who is a Covered Person has reached the Limiting Age, coverage may continue if the child is, and remains, incapable of self-sustaining employment, by reason of mental or physical handicap, and is chiefly dependent upon the Certificateholder for support and maintenance. The child will continue as a Covered Person if:

1. The Certificateholder sends written proof of the child's incapacity no later than 31 days after the premium due date which coincides with or next follows the child's attainment of the Limiting Age;
2. The Certificateholder furnishes, upon request, proof of the child's incapacity and dependency during the two years following the child's attainment of Limiting Age;
3. The Certificateholder furnishes proof of the child's incapacity and dependency once a year after the two-year period described in 2 above; and
4. The Certificateholder pays the premium for the child. This will be on the same basis as that for an adult of like age and sex. Extension of coverage will not continue for any child named in the Enrollment Application whose disabling condition existed prior to the Certificate Date of such child's coverage and was not disclosed in the Enrollment Application.

TOTAL DISABILITY

"Total Disability" means a Covered Person's inability, because of Sickness or Injury, to perform the material and substantial duties of his/her occupation.

If a Covered Person suffers from Total Disability at the time of any termination or discontinuance of this Policy by ANTEX, regardless of the reason for the termination or discontinuance, ANTEX will provide an extension of benefits for a period of 12 months immediately following the date of termination or discontinuance. Benefits payable will be subject to this Policy's regular benefit limits.

CONVERSION PRIVILEGE

If coverage under this Policy has been terminated, Covered Persons are entitled to have a conversion policy issued by ANTEX, without evidence of insurability, subject to the following terms and conditions:

1. A conversion policy is not available to a Covered Person if termination of his insurance under this Policy occurs:
   a) Because he/she failed to make timely payment of any required premium; or
   b) For any other reason, and he/she had not been continuously covered under this Policy, and for similar benefits under any group policy which it replaced, during the entire three (3) months period ending with such termination; or
   c) Because this Policy terminated and the insurance was replaced by similar coverage under another group policy within thirty-one (31) days of the date of termination; and

2. Written application and the first premium payment for the conversion policy shall be made to ANTEX not later than thirty-one (31) days after such termination.

The premium for the conversion policy shall be determined in accordance with ANTEX's table of premium rates applicable to the age and class of risk of each person to be covered under that policy and to the type and amount of insurance provided.

The conversion policy shall cover the Covered Persons on the date his/her coverage terminates under this Policy. At the option of ANTEX, a separate conversion policy may be issued to cover any dependent. ANTEX shall not be required to issue a conversion policy covering any person if such person is or could be covered by Medicare. Furthermore, ANTEX shall not be required to issue a conversion policy covering any person if:

1. Such person is or could be covered for similar benefits under an individual policy; such person is or could be covered for similar benefits under any arrangement of coverage for an individual in a group, whether insured or uninsured; or similar benefits are provided for or available to such person by reason of any state or federal law; and

2. The benefits under sources described in paragraph (1) above for such person, or benefits provided or available under sources described in paragraph (1) above for such person, together with the conversion policy's benefits would result in overinsurance according to ANTEX's standards for overinsurance.

The conversion policy will not exclude, as a Pre-Existing Condition, any condition covered by this Policy; provided, however, that the conversion policy may provide for a reduction of its hospital, surgical, or medical benefits by the amount of any such benefits payable under this Policy after the individual's insurance terminates.

COORDINATION OF BENEFITS

The Coordination of Benefits (COB) provision applies when a Covered Person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans does not exceed 100% of the total Allowable expense.

DEFINITIONS

A. A **Plan** is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts:

(1) **Plan** includes: group and nongroup insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

(2) **Plan** does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

B. **"This Plan"** means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. The order of benefit determination rules determine whether This plan is a Primary plan or Secondary plan when the Covered Person has health care coverage under more than one Plan.

When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

D. Allowable expense is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the Covered Person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering the Covered Person is not an Allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered Covered Person is not an Allowable expense.

The following are examples of expenses that are not Allowable expenses:

(1) The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.

(2) If a Covered Person is covered by 2 or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.

(3) If a Covered Person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.

(4) If a Covered Person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary plan's payment arrangement shall be the Allowable expense for all Plans. However, if the provider has contracted with the Secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary plan to determine its benefits.

(5) The amount of any benefit reduction by the Primary plan because a Covered Person has failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

E. Closed panel plan is a Plan that provides health care benefits to Covered Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

F. Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When a Covered Person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

A. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.

B. (1) Except as provided in Paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary.

(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide out-of-network benefits.

C. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

D. Each Plan determines its order of benefits using the first of the following rules that apply:

(1) Non-Dependent or Dependent. The Plan that covers the Covered Person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary plan and the Plan that covers the Covered Person as a dependent is the Secondary plan. However, if the Covered Person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the Covered Person as a dependent; and primary to the Plan covering the Covered Person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the Covered Person as an employee, member, policyholder, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.

(2) Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

The Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or
If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.

(b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

1. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
2. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;

3. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or
4. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

    a) The Plan covering the Custodial parent;
    b) The Plan covering the spouse of the Custodial parent;
    c) The Plan covering the non-custodial parent; and then
    d) The Plan covering the spouse of the non-custodial parent.

(c) For a dependent child covered under more than one Plan of individuals who are the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

(3) Active Employee or Retired or Laid-off Employee. The Plan that covers a Covered Person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same Covered Person as a retired or laid-off employee is the Secondary plan. The same would hold true if a Covered Person is a dependent of an active employee and that same Covered Person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(4) COBRA or State Continuation Coverage. If a Covered Person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the Covered Person as an employee, member, subscriber or retiree or covering the Covered Person as a dependent of an employee, member, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(5) Longer or Shorter Length of Coverage. The Plan that covered the Covered Person as an employee, member, policyholder, subscriber or retiree longer is the Primary plan and the Plan that covered the Covered Person the shorter period of time is the Secondary plan.

(6) If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This plan will not pay more than it would have paid had it been the Primary plan.

EFFECT ON THE BENEFITS OF THIS PLAN

A. When This plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary plan. The Secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim. In addition, the Secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If a Covered Person is enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed panel plan, COB shall not apply between that Plan and other Closed panel plans.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This plan and other Plans. ANTEX may get the facts it needs from or give them to other organizations or Covered Persons for the purpose of applying these rules and determining benefits payable under This plan and other Plans covering the Covered Person claiming benefits. ANTEX need not tell, or get the consent

of, any person to do this. Each Covered Person claiming benefits under This plan must give ANTEX any facts it needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another Plan may include an amount that should have been paid under This plan. If it does, ANTEX may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This plan. ANTEX will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY
If the amount of the payments made by ANTEX is more than it should have paid under this COB provision, it may recover the excess from one or more of the Covered Persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the Covered Person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

GENERAL PROVISIONS

ENTIRE CONTRACT -- The Entire Contract will consist of:

1. This Policy;
2. The Application of the Group Policyholder, which will be attached to this Policy;
3. Any Enrollment Applications and attached papers for the proposed Covered Persons; and
4. Any riders, endorsements or amendments issued with or added to this Policy or any Certificate which is a part of this Policy.

We will deem all the statements provided in the Enrollment Application and attached supplements, except fraudulent statements, as representations and not warranties.

TIME LIMIT ON CERTAIN DEFENSES --

1. <u>MISSTATEMENTS IN THE ENROLLMENT APPLICATION</u> --

We may only use fraudulent misstatements in the Enrollment Application to void coverage under this Policy or to deny any claim for loss incurred more than 24 months after the Covered Person's Certificate Date.
2. <u>PRE-EXISTING CONDITIONS</u> --
No claim for loss incurred by a Covered Person after 12 months from his/her Certificate Date will be reduced or denied because a Sickness or Injury, not excluded by name or specific description before the date of loss, existed within 12 months before his/her Certificate Date.

REINSTATEMENT -- Coverage terminates if the Certificateholder does not pay a periodic premium payment before the end of the Grace Period. Our later acceptance of premium, (or one of our authorized agent's acceptance of premium) without requiring an application for reinstatement, reinstates coverage under this Policy.

We will require an application for reinstatement. We will subject all representations made in this application to all of the provisions of this Policy, including TIME LIMIT ON CERTAIN DEFENSES. If We approve the application for reinstatement, We will reinstate coverage as of the approval date of the reinstatement Enrollment Application. If We do not approve the reinstatement and do not notify the Certificateholder in writing of the disapproval, We must reinstate coverage. The reinstatement will take place on the 45th day following the date of Our receipt of the application for reinstatement.

The reinstated plan only covers loss resulting from:

1. Injury that occurs after reinstatement; and
2. Sickness that begins ten days or more after the Covered Person's date of reinstatement.

3. In all other respects, the Covered Person's rights and Our rights will remain the same, except as stated in any application attached to the reinstated coverage.

4. We will apply any premiums that We accept for reinstatement to a period for which the Certificateholder has not paid premiums. We will not apply any premium to any period more than 60 days before the reinstatement date.

WE WILL NOT CONSIDER A REQUEST FOR REINSTATEMENT THAT THE CERTIFICATEHOLDER MAKES MORE THAN 180 DAYS AFTER HIS/HER COVERAGE UNDER THIS POLICY HAS TERMINATED.

GRACE PERIOD -- There is a 31 day grace period for the payment of any premium. If a renewal premium is not paid on or before its due date, it may be paid during the following 31 days. If We do not receive the payment during this Grace Period, We will terminate coverage. Termination will be effective as of the end of the period for which premium was paid. The Grace Period does not apply if the Company has provided a notice of intent to terminate this Policy.

NOTICE OF CLAIMS -- A claimant must give notice of claim within 30 days after a covered loss starts or as soon as reasonably possible. The claimant must give the notice to Us at Our Home Office in Galveston, Texas. The notice must include the claimant's name and his/her Certificate Number.

CLAIM FORMS -- When We receive notice of claim, We will send the claimant forms for filing Proof of Loss. If We do not mail the claimant these forms within 15 days of Our receipt of his/her request, the claimant will have met the Proof of Loss requirement. However, the claimant must still give Us a written statement of the nature and extent of the loss within the time limit stated in the Proof of Loss section.

PROOFS OF LOSS -- The claimant must give written Proof of Loss to the Home Office in Galveston, Texas within 90 days after such loss. If it was not reasonably possible for the claimant to give the Proof of Loss in the time required, We will not reduce or deny the claim as long as the claimant gives proof as soon as reasonably possible. In any event, the claimant must give proof no later than 1 year from the time specified, unless the claimant was legally incapacitated.

TIME FOR PAYMENT OF CLAIMS -- All benefits payable under this Policy will be paid immediately upon receipt of Proof of Loss.

PAYMENT OF CLAIMS -- We will pay Policy benefits to the Certificateholder. If the Certificateholder has assigned benefits, We will pay the benefits to the respective assignee. If the Certificateholder has died, We will pay any unpaid benefits to his/her estate. We may pay benefits up to [$1,000] to someone related to the Certificateholder by blood or marriage or to any other person We deem entitled to the benefits if:

A court has deemed the Certificateholder incompetent; or
The Certificateholder has died and his/her estate is not able to execute a valid release.

NO ASSUMPTION OF LIABILITY -- Our payment of any claim does not mean We have assumed liability for future payments for the same condition or any related condition once:

We determine that no Medical Service charges exist; or
We determine that Our payment was erroneous or inappropriate.

PHYSICAL EXAMINATIONS -- We have the right to have any Covered Person examined as often as reasonably required while a claim is pending for that person. We will pay for the requested physical examination.

LEGAL ACTIONS -- No legal action may be brought to recover on this Policy within 60 days after a claimant gives written Proof of Loss. No legal action may be brought after 3 years from the time this Policy requires written proof of loss.

LIMITATION OF LIABILITY -- The Certificateholder agrees that Our maximum liability under this Policy and related matters is limited to:

1. Policy benefits otherwise payable;
2. The Certificateholder's reasonable attorneys fees, if any; and
3. Any statutory penalties that may be imposed.

TERMINATION OF THIS POLICY -- ANTEX or the Group Policyholder may terminate this Policy, as described under **TERMINATION OF COVERAGE**, provided written notice is provided 31 days in advance to the other party.

MISSTATEMENTS OF AGE -- If a Covered Person has misstated his/her age, the benefits will be those the premium paid would have purchased if the correct age had been disclosed. However, if on the Certificate Date, We would not have granted coverage because of the Covered Person's correct age, We are only liable for the return of any premiums paid on account of such person.

CONFORMITY WITH STATE STATUTES -- Any provision of this Policy which, on the Certificate Date, is in conflict with the laws of the state in which the Certificateholder resides on that date is amended to conform to the minimum requirements of the laws of the state.

ILLEGAL OCCUPATION -- We will not be liable for any loss that results from a Covered Person engaging in an illegal occupation or committing or attempting to commit a felony.

ASSIGNMENT -- No assignment of interest under this Policy will be binding upon ANTEX unless and until We receive the original or a duplicate of the assignment at Our Home Office in Galveston, Texas. Any assignment will be subject to any right of offset that We may be entitled to assert. We are not responsible for the validity or sufficiency of any assignment. If We pay the assignor, We are not liable for payment to the assignee.

AUTHORITY, AMENDMENT, AND ALTERATION -- Neither ANTEX nor the Group Policyholder may modify any terms of this Policy except by a written agreement signed by one of Our officers. Neither ANTEX nor the Group Policyholder may waive any forfeiture under this Policy except by a written agreement signed by one of Our officers. ANTEX may not delegate the authority for the purposes of this provision. ANTEX may amend or change this Policy at any time, subject to the laws of the jurisdiction in which We delivered this Policy. In this case, We may amend or change this Policy by written agreement between the Group Policyholder and Us and without the consent of the Covered Persons or his/her beneficiaries, if any. No agent has the authority to waive an answer to any question in the application, determine insurability, make or alter any contract or waive any of ANTEX's other rights or requirements. No change in this Policy will be valid unless evidenced by endorsement on this Policy or by a signed amendment to this Policy.

ELECTRONIC ACCOUNT DEBIT AUTHORIZATION -- If the Certificateholder has chosen Electronic Account Debit as his/her method of payment, he/she agrees that:

1. We are authorized to debit the Certificateholder's named account for required payments;
2. The account debit will be made electronically without the signature of any officer or employee of ANTEX;
3. We will not provide a receipt for any account debit;
4. ANTEX will not incur any liability because of dishonor of the account debit;
5. Upon refusal of the financial institution to honor any attempted debit of the named account, We will cease to debit the Certificateholder's account. We will send the Certificateholder written notice requesting payment in full of the required premium. Upon the Certificateholder's payment of the required premium, We will again begin to debit the Certificateholder's account. However, if the Certificateholder does not pay the required premium, the Certificateholder's coverage will lapse in accordance with the Grace Period provision; and
6. Except as provided in (4) above, the authorization remains effective unless either party ends the authorization. Before ending the authorization, a party must provide the other party at least 30 days advance written notice. We are not liable for amounts debited from the Certificateholder's account prior to Our receipt of written notification to end coverage.

DIRECT PAYMENT TO PUBLIC HOSPITALS AND CLINICS -- Benefits to a Covered Person shall be paid, with or without an assignment from the Covered Person, to public Hospitals or clinics for services and supplies provided to the Covered Person if a proper claim is submitted by the public Hospital or clinic. No benefits shall be paid under this provision to the public Hospital or clinic if such benefits have been paid to the Covered Person prior to receipt of the claim by ANTEX. Payment to the public Hospital or clinic of benefits pursuant to this provision shall discharge ANTEX from all liability to the Covered Person to the extent of the benefits so paid. Nothing in this provision shall be construed to require payment of benefits for the same services or supplies to both the Covered Person and the public Hospital or clinic.

AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS
HOME OFFICE: ONE MOODY PLAZA
GALVESTON, TEXAS

GROUP HOSPITAL INSURANCE POLICY

THIS POLICY PROVIDES COVERAGE FOR HOSPITAL EXPENSES DESCRIBED IN THIS POLICY AND THE CERTIFICATE. WHEN SELECTED, A PREFERRED PROVIDER COMPONENT IS INCLUDED WITH THIS COVERAGE.

BYLAWS OF

NATIONAL BUSINESS ASSOCIATION

* *

ARTICLE I.

OFFICES

1.01 Registered Office and agent. The registered office of the association shall be at Monroe House, 237 East High Street, Jefferson, Missouri. The name of the registered agent at that address is Nicholas Monaco.

1.02 Principal Place of Business. The principal place of business of the association shall be in the State of Texas, unless and until decided otherwise by the Board of Directors.

1.03 Other Offices. The association may also have offices at other places in or out of the State of incorporation, as the Board of Directors may determine, or as the business of the association may require.

ARTICLE II.

MEMBERS

2.01 Place of Meeting. Meetings of the members may be held at such time and place, within or without the United States, as shall be stated in the notice of the meeting, or in a duly executed waiver of notice thereof.

2.02 Annual Meetings. Annual meetings of members, commencing with the year of 1991, shall be held on the first Tuesday in January in each year, if not a legal holiday, and if a legal holiday, then on the next secular day following, at 10:00 a.m. at which they shall elect, by a plurality vote, a Board of Directors and transact such other business as may properly be brought before the meeting. In the notice of the Annual Meeting the Board of Directors shall recommend a slate of directors to fill the term of any directors whose terms have expired. Any member at least sixty (60) days prior to the notice date for the Annual Meeting may, by written notice to the association, request that any member of the association be nominated as a director. The Notice of Annual Meeting shall include any nomination from the membership and such nominee shall be eligible for election at the Annual Meeting.

2.03 Special Meetings. Special meetings of the members, for any purpose or purposes, unless otherwise prescribed by statute or by the Articles of Incorporation, may be called by the Chairman of the Board or the President, and shall be called by the President

or Secretary at the request in writing of a majority of the Board of Directors, or, at the request in writing of members constituting at least 10% of the total membership. Such request shall state the purpose or purposes of the proposed meeting. Business transacted at the Annual Meeting or Special Meeting of members shall be limited to the purposes stated in the notice of the meeting.

2.04 Notice. Notices of meetings shall be in writing and signed by the President, a Vice President, the Secretary, an Assistant Secretary, or by such other person or persons as the Board of Directors shall designate. Such notice shall state the place, day and hour of the meeting and, in case of a Special Meeting, the purpose or purposes for which the meeting is called. A copy of such notice shall be either delivered personally or shall be mailed, postage prepaid, to each member of record entitled to vote at such meeting not less than ten (10) days nor more than sixty (60) days before such meeting. Personal delivery of any such notice to any officer of a Corporation or association, or to any member of a partnership shall constitute delivery of such notice to such association or partnership.

2.05 Quorum; Withdrawal of Quorum. Those members present in person or by proxy at an Annual or Special Meeting shall constitute a quorum.

2.06 Majority Vote. When a quorum is present or represented at any meeting, the vote of a majority of the members having voting power present in person or represented by proxy shall decide any question brought before such meeting, unless the question is one upon which by express provisions of the statutes or of the Articles of Incorporation a different vote is required, in which case such express provision shall govern and control the decision of such question.

2.07 Voting List. The officer or agent having charge of the association membership list shall make, at least ten (10) days before each meeting of members, a complete list of the members entitled to vote at such meeting or any adjournment thereof, arranged in alphabetical order, with the address of each. Such list, for a period of ten (10) days prior to such meeting, shall be kept on file at the principle office of the association and shall be subject to inspection by any member at any time during the usual business hours. Such list shall also be produced and kept open at the time and place of the meeting during the whole time of the meeting, and shall be subject to the inspection of any member who may be present. However, failure to comply with this provision will not invalidate any meeting.

2.08 Number of Votes. Each member, regardless of class, shall be entitled to one vote on each matter submitted to a vote at a meeting of members, except to the extent that the voting rights of the shares of any class or classes are limited or denied by the Articles of Incorporation.

2.09 Proxies. At any meeting of the members, any member may be represented and vote by a proxy appointed by an instrument in writing. Such proxy shall be filed with the Secretary of the association prior to or at the time of the meeting. In the event that any such written instrument shall designate two or more persons to act as proxies, a majority of such persons present at the meeting (or, if only one shall be present, then that one) shall have and may exercise all of the powers conferred by such written instrument upon all of the persons so designated, unless the instrument shall otherwise provide. No such proxy shall be valid after the expiration of eleven (11) months from the date of its execution, unless otherwise provided in the proxy. Each proxy shall be revocable before it has been voted unless the proxy form conspicuously states that the proxy is irrevocable and the proxy is coupled with an interest. A revocable proxy shall be deemed to have been revoked if the Secretary of the association shall have received at or before the meeting, instructions or proxy shall have been duly executed and dated in writing by the member.

ARTICLE III.

DIRECTORS

3.01 Management. The business and affairs of the association shall be managed by the Board of Directors, who may exercise such powers of the association and do all such lawful acts and things as are not (by statute, Articles of Incorporation, or these Bylaws) directed or required to be exercised or done by the association.

3.02 Number and Qualifications. The Board of Directors shall consist of not less than three (3), nor more than seven (7) directors. Each director shall hold office for a staggered term of two (2) years or until his successor is elected and qualified. All directors of the association shall be members of the association.

3.03 Election. The directors whose terms have expired shall be elected at the Annual Meeting of the members, except as provided in Bylaws 3.05 and 3.06. Each director elected shall hold office until his successor shall be elected and qualified. Directors shall be elected by majority vote of the members at the Annual Meeting.

3.04 Change in Number. The number of directors may be increased or decreased from time to time by amendment of these Bylaws, but no decrease shall have the effect of shortening the term of any incumbent director. Any directorship to be filled by reason of an increase in the number of directors shall be filled by an election at an Annual Meeting or at a Special Meeting of the association called for that purpose.

3.05 Removal. Any director may be removed, either with or without cause, at any special or annual meeting of the association, by the affirmative vote of a majority of the members present, in person or by proxy, having voting power at such meeting, if notice of intention to act upon such matter shall have been given in the notice calling such meeting or in the waiver of such notice. If the notice calling such meeting or the waiver of notice of such meeting, shall so provide, the vacancy caused by such removal may be filled at such meeting by an affirmative vote of a majority of the members present, in person or by proxy, having voting power to elect a director to fill the vacancy. Failure to elect a director to fill the unexpired term of the director so removed shall be deemed to create a vacancy on the Board of Directors.

3.06 Vacancies. Any vacancy occurring in the Board of Directors (by death, resignation, removal or otherwise) may be filled by the affirmative vote of a majority of the remaining directors. A director elected to fill a vacancy shall be elected for the unexpired term of his predecessor's office.

3.07 Place of Meetings. See Bylaw 5.03.

3.08 Annual Meetings. An annual meeting of the Board of Directors shall be held each year on a day to be selected by the Board of Directors. If the day selected is a legal holiday, then the meeting shall be held on the next business day following. At the meeting, the directors shall elect directors, officers, and transact such other business as may properly be brought before the meeting. If the annual meeting is not held on such date, the election of directors and officers may be held at any meeting of the directors thereafter called pursuant to these bylaws.

3.09 Regular Meetings. Regular meetings of the Board of Directors may be held at such time and place as shall from time to time be determined by the board.

3.10 Special Meetings. Special meetings of the Board of Directors may be called at any time by the president or by any two (2) directors. Notice of the meeting shall be given to each director at least two (2) days before such meeting. The purpose of such meeting need not be specified, unless otherwise required by statute, the Articles of Incorporation, or these Bylaws.

3.11 Notice. Written or printed notice stating the day, hour, place and purposes of the meeting shall be delivered not less than ten (10) nor more than fifty (50) days before the date of the meeting, either personally or by mail, by or at the direction of the President, the Secretary, or the officer in person calling the meeting, to each director. See also Bylaws 5.01 and 5.02.

3.12 Majority Vote. The vote of the holders of a majority of the directors, present, in person or by proxy, shall decide any question brought before such meeting. If a statute, the Articles of Incorporation or these bylaws expressly require a higher vote, the higher vote shall govern.

3.13 Quorum. A majority of the number of elected directors fixed by these Bylaws shall constitute a quorum for the transaction of business. A director present by proxy may not be counted toward a quorum. Except as otherwise specifically provided by statute, the Articles of Incorporation, or these Bylaws, the act of a majority of the directors present at a meeting at which a quorum is present shall be the act of the Board of Directors. If a quorum is not present at a meeting of the Board of Directors, the directors present may adjourn the meeting from time to time, without notice, other than announcement at the meeting, until a quorum is present.

3.14 Compensation. Upon resolution by the Board of Directors, the directors may be paid their expenses, if any, of attendance at each meeting of the Board of Directors. They may also be paid a fixed sum for attendance at each Directors meeting, or a stated salary as director, upon a resolution by the Board of Directors.

3.15 Procedure. The Board of Directors shall keep regular minutes of its proceedings. The minutes shall be placed in the minute book of the association.

3.16 Telephone and Similar Meetings. See Bylaw 5.05.

3.17 Interested Directors, Officers and Members.

(A) Validity Unaffected. If paragraph 3.18(B) is satisfied, no contract, act or transaction between this association and any of its directors and officers, or any firm, trust or association in which any of them are directly or indirectly interested, shall be affected or invalidated solely because of this relationship or because of the presence of a director or officer at the meeting authorizing the contract or transaction, or his participation, or both in the meeting or authorization. No duty to pay damages to this association shall be imposed upon any director or officer of this association solely by reason of such fact, regardless of the vote, action or presence of any such director.

(B) Disclosure; Approval; Fairness. Paragraph 3.18(A) shall only apply if:

(1) the material facts of the relationship or interest of each director is known or disclosed

(a) to the Board of Directors, and the board authorizes or ratifies the contract, act or transaction by a vote of the majority of the Directors present (each interested director shall be counted in determining whether a quorum is present, but not counted in determining the majority necessary to carry the vote); or

(2) the contract, act or transaction is fair to the association as of the time it is authorized or ratified by the Board of Directors.

(C) Non-exclusive. This provision shall not be construed to invalidate a contract, act or transaction which would be valid in the absence of this provision.

ARTICLE IV.

EXECUTIVE COMMITTEE

4.01 Designation. By resolution of a majority of the whole board, the Board of Directors may designate an executive committee who must be members of the association.

4.02 Number, Qualification and Term. The executive committee shall consist of one (1) or more directors. The president shall be a member of the executive committee. The executive committee shall serve at the pleasure of the Board of Directors.

4.03 Authority. To the extent provided in a resolution adopted by a majority of the whole board, the executive committee shall have and may exercise all of the authority of the Board of Directors in the management of the business and affairs of the association. The executive committee shall not have the authority to:

(A) amend the Articles of Incorporation;

(B) approve a plan of merger or consolidation;

(C) recommend to the association the sale, lease or exchange of all or substantially all of the assets of the association;

(D) recommend to the association the voluntary dissolution, or revocation of a voluntary dissolution, of the association;

(E) amend, alter or repeal these Bylaws, or adopt new Bylaws

(F) fill vacancies in, or remove members of, the Board of Directors;

(G) fill vacancies in, or remove any members of, a committee appointed by the Board of Directors;

(H) elect or remove officers;

(I) elect or remove members of any committee;

(J) fix the compensation of the members of any committee;

(K) alter or repeal any resolution of the Board of Directors which provides that it shall not be amendable or repealable.

4.04 Change in Number. By resolution adopted by a majority of the whole Board of Directors, the number of members of the executive committee may be increased or decreased.

4.05 Removal. A member of the executive committee may be removed by the vote of the majority of the whole Board of Directors, whenever, in their judgment, the best interests of the association would be served by such removal

4.06 Vacancies. A vacancy occurring because of death, resignation, removal or any other reason may be filled in the manner provided for original designation in Bylaw 4.01.

4.07 Meetings. Time, place and notice (if any) of executive committee meetings shall be determined by the executive committee. See also Bylaws 5.01, 5.02 and 5.03.

4.08 Quorum; Majority Vote. A majority of the number of members designated by the Board of Directors shall constitute a quorum for the transaction of business. Except as specifically provided by statute, the Articles of Incorporation, or these Bylaws, the act of a majority of the members present at any meeting at which a quorum is present shall be the act of the executive committee. If a quorum is not present at a meeting, the members present may adjourn the meeting, from time to time, without notice, other than an announcement at the meeting, until a quorum is present. See also Bylaw 3.13.

4.09 Compensation. See Bylaw 3.12.

4.10 Procedure. The executive committee shall keep regular minutes of its proceedings and report the same to the Board of Directors when required. The minutes of the proceedings of the executive committee shall be placed in the minute book of the association.

4.12 Telephone and Similar Meetings. See Bylaw 5.05.

4.13 Responsibility. The designation of an executive committee, and the delegation of authority to it, shall not operate to relieve the Board of Directors, or any member of the board, of any responsibility imposed on it, or him, by law.

ARTICLE V.

MEETINGS

5.01 Notices. Whenever notice is required to be given (by statute, the Articles of Incorporation, these Bylaws or otherwise to a director, committee member or security holder and no provision specifies how notice is to be given, such notice shall be written or printed, and may be given:

(A) in person;

(B) by mail, postage prepaid, addressed to the director, committee member, or security holder at the address appearing on the books of the association (any notice required or permitted to be given by mail shall be deemed given at the time when the same is thus deposited in the United States mail); or

(C) in any other method permitted by law.

5.02 Waiver. Whenever notice is required to be given (by statute, the Articles of Incorporation or these Bylaws) to a security holder, committee member or director, a waiver thereof, in writing, signed by the person, or persons, entitled to such notice, whether before or after the time stated in such notice, shall be equivalent to the giving of such notice. Attendance at a meeting shall constitute a waiver of notice of such meeting, except where a person attends for the express purpose of objecting to the transaction of any business on the ground that the meeting is not lawfully called or convened. The waiver of notice shall state the date, time and place of such meeting, and if required by statute, the Articles of Incorporation, or these Bylaws, it shall also state the business to be transacted at such meeting.

5.03 Place of Meetings. Meetings of the Board of Directors or committees shall be held at the date, time and place, in or out of the state of incorporation, as the Board of Directors may determine. Committees may set the date, time and place of their meetings. In the absence of such action by a committee. The Board of Directors may set the time and place of committee meetings. If no place is designated for the meeting, the meeting shall be held at the principal offices of the association.

5.04 Telephone and Similar Meetings. Directors and committee members may participate in and hold a meeting by means of conference telephone, or similar communications equipment by means

of which all persons participating in the meeting can hear each other. Participation in such a meeting shall constitute presence in person at the meeting, except where a person participates in the meeting for the express purpose of objecting to the transaction of any business on the ground that the meeting is not lawfully called or convened.

ARTICLE VI.

OFFICERS AND AGENTS

6.01 Number.

(A) The association shall have:

(1) a president, vice president, secretary and a treasurer and

(2) such other officers (including a chairman of the board and additional vice presidents), assistant officers and agents as the Board of Directors deems necessary.

(B) Officers and agents of the association do not need to be directors of the association, nor residents of the state of incorporation.

(C) Any two (2) offices may be held by the same person.

6.02 Election. Officers named in Bylaw 6.01(A)(1) shall be elected by the Board of Directors on the expiration of an officer's term, or whenever a vacancy exists. Officers named in Bylaw 6.01(A)(2) may be elected by the Board at any meeting.

6.03 Term. Unless otherwise specified at the time of election appointment or in an employment contract approved by the Board, each officer's and agent's term shall end at the annual meeting of the Board of Directors. Each officer and agent shall serve until the end of his or her term, or his or her death, resignation or removal.

6.04 Removal. Any officer or agent elected or appointed by the Board of Directors may be removed by a vote of a majority of the whole board whenever the board determines that the best interests of the association would be served by such removal. The contract rights of a removed person shall not be prejudiced by such a removal. Election or appointment of an officer or agent shall not, of itself, create contract rights.

6.05 Vacancies. Any vacancy occurring in any office (by death, resignation, removal, increase in the number of officers of the association or otherwise) shall be filled by the Board of Directors. The officer or agent filling the vacancy shall hold office until his successor is elected.

6.06 Authority. Officers and agents shall have the authority and perform duties in managing the association as provided in these Bylaws, or as determined by resolution of the Board of Directors.

6.07 Compensation. The Board of Directors shall fix the compensation of the officers and agents of the association.

6.08 President. The president shall be the chief executive officer of the association. He shall preside at all meetings of the association and the Board of Directors. He shall have general and active management of the business and affairs of the association. He shall see that all orders and resolutions of the Board are carried into effect. He shall perform such other duties and have such other authority and power as the Board of Directors may prescribe. Upon demand of a majority of the directors, he may call special meetings of the directors.

6.09 Vice President. Unless the Board of Directors determines otherwise, the vice presidents, in the order of their seniority, shall perform the duties, and shall have the authority and exercise the powers of the president whenever the president is absent or disabled. They shall perform such other duties and have such other authority and powers as the Board of Directors may prescribe, or as the president may delegate.

6.10 Secretary.

(A) The secretary shall attend all meetings of the association and of the Board of Directors. He shall also keep, or cause to be kept, in a book provided for that purpose, a true and complete record of the proceedings at such meetings, and shall perform a like duty for all committees appointed by the Board of Directors, when required.

(B) He shall give, or cause to be given, notice of all meetings of the association and the Board of Directors.

(C) He shall keep the association's seal in safe custody. When authorized by the Board of Directors or the executive committee, he shall affix the seal to any instrument requiring it. When affixed, it shall be attested by the signature of the secretary, or by the treasurer or assistant secretary.

(D) He shall be under the supervision of the president. He shall perform such other duties and have such other authority and powers as the Board of Directors may prescribe, or as the president may delegate.

6.11 Assistant Secretary. Unless the Board of Directors determines otherwise, the assistant secretaries, in the order of their seniority, shall perform the duties, and shall have the authority and exercise the powers of the secretary whenever the

secretary is absent or disabled. They shall perform such other duties and have such other powers as the Board of Directors prescribes, or the president may delegate.

6.12 Treasurer.

(A) The treasurer shall have custody of the corporate funds and securities. He shall keep, or cause to be kept, full and accurate accounts of receipts and disbursements of the association. He shall deposit all funds and other valuables in the name and to the credit of the association in depositories designated by the Board of Directors.

(B) He shall disburse funds of the association as ordered by the Board of Directors, and he shall prepare financial statements as they direct.

(C) If the Board of Directors requires, he shall give the association a bond (in such form, sum and with such surety or sureties, as shall be satisfactory to the Board) for the faithful performance of the duties of his office and for the restoration to the association in case of his death, resignation, retirement or removal from office, of all books, papers, vouchers, money and other property, of whatever kind, in his possession or under his control belonging to the association.

(D) He shall perform such other duties and have such other authority and powers as the Board of Directors may prescribe, or as the president may delegate.

6.13 Assistant Treasurer. Unless otherwise determined by the Board of Directors, the assistant treasurers, in the order of their seniority, shall perform the duties and have the authority and exercise the powers of the treasurer whenever the treasurer is absent or disabled.

ARTICLE VII.

GENERAL PROVISIONS

7.01 Books and Records. The association shall keep correct and complete books and records of account. It shall keep minutes of the proceedings of its Board of Directors and committees. The Board of Directors shall maintain current, true, and accurate financial records with full and correct entries made with respect to all financial transactions of the association, including all income and expenditures, in accordance with generally accepted accounting principles. All records, books, and annual reports of the financial activity of the association shall be kept at the registered office or principal office of the association in this state for at least three years after closing of such fiscal year.

7.02 Annual Statement. The Board of Directors shall prepare, or cause to be prepared, a full and clear statement of the financial activity of the association, including a statement of support, revenue and expenses and changes in fund balances, a statement of financial expenses, and balance sheets, for all funds for the last fiscal year and for the prior fiscal year, all prepared in conformity with accounting standards as promulgated by the American Institute of Certified Public Accountants.

7.03 Checks and Notes. Checks, demands for money, and notes of the association shall be signed by an officer, or officers, or other person or persons, designated from time to time by the Board of Directors. Unless it is otherwise required by statute or directed by the Board of Directors, such instruments may be signed by any one (1) of the officers of the association. All deeds, mortgages, and other written contracts and agreements to which the association shall become a party, may, unless otherwise directed by the Board of Directors, or unless otherwise required by law, be signed by the president. The Board of Directors may, at any time, designate officers, or employees of the association, other than those named above, who may, in the name of the association, sign any of such instruments.

7.04 Fiscal Year. The fiscal year of the association shall be fixed by the Board of Directors.

7.05 Seal. The association seal (of which there may be one or more exemplars) shall contain the name of the association and the name of the state of incorporation. The seal may be used by impressing it, or reproducing a facsimile of it, or otherwise.

7.06 Indemnification.

(A) Persons Covered. The association shall indemnify, to the extent provided in paragraphs 7.06(B), 7.06(C), 7.06(D), 7.06(F), 7.06(G) or 7.06(H):

(1) any person who is, or was, a director, officer, agent, or employee of the association; and

(2) any person who serves, or served, at the association's request, as a director, officer, agent, employee, partner or trustee of another association, or of a partnership, joint venture, trust, or other enterprise.

(B) Extent of Coverage. The association shall indemnify a person named in paragraph 7.06(A) who was, is, or is threatened to be made a named defendant or respondent in a proceeding because the person is or was a director, officer, agent, or employee named in paragraph 7.06(A)(2), or held or holds a position named in paragraph 7.06(A), if the person satisfies the standard in paragraph 7.06(C), for judgment, penalties (including

excise and similar taxes), fines, settlements, and reasonable expenses actually incurred by the person in connection with the proceeding.

(C) Requirements for Indemnification. In case of a proceeding involving a person named in paragraph 7.06(A), such person shall be indemnified under 7.06(B) only if it is determined that the person:

(1) conducted himself in good faith;

(2) reasonably believed:

(a) in the case of conduct in his official capacity as a director of the association, that his conduct was in the association's best interest; and

(b) in all other cases, that his conduct was at least not opposed to the association's best interests; and

(3) in the case of any criminal proceeding, had no reasonable cause to believe his conduct was unlawful.

(D) Bar to Indemnification. A person shall not be indemnified under 7.06(C) in respect of any obligations resulting from a proceeding in which he is found liable on the basis that personal benefit was improperly received by him, whether or not the benefit resulted from an action taken in the person's official capacity or in which he is found liable to the association.

(E) The Determination Standard Met. A determination of indemnification under paragraph 7.06(B) must be made:

(1) by a majority vote of a quorum consisting of directors who at the time of the vote are not named defendants or respondents in the proceeding;

(2) if a quorum of the directors cannot be obtained, by a majority vote of a committee of the board of directors consisting solely of two or more directors who are at time of vote not named defendants or respondents in the proceeding, designated to act in the matter by a majority vote of all the directors; or

(3) by special legal counsel selected by a majority vote of the board of directors (whether or not there is a quorum) or a committee of the board (as designated in subparagraph 7.06(E)(2).

(F) Advance Payments. The association may pay, in advance, any reasonable expenses (including court costs and attorney fees) which may become subject to indemnification under paragraphs 7.06(A)-7.06(E) if:

(1) the association receives a written affirmation by the person receiving the payment of his good faith belief that he has not met the standard of conduct necessary for indemnification, and it is determined that the fact then known would not preclude indemnification;

(2) the person receiving the payment undertakes, in writing, to repay, if it is ultimately determined that he is not entitled to indemnification under paragraphs 7.06(A)-7.06(E); or

(3) determinations and authorizations of payments made under this paragraph [7.06(F)] must be made in the manner specified by paragraph 7.06(E).

(G) Witness Expenses. The association may pay or reimburse expenses incurred by a person named in paragraph 7.06(A) in connection with his appearance as a witness or other participation in a proceeding at a time when he is not a named defendant or respondent in the proceeding.

(H) Determination of Reasonableness. Determination as to the reasonableness of expenses must be made in the same manner as the determination that indemnification is permissible and as the authorization of indemnification under paragraph 7.06(E), except that if the determination that indemnification is permissible is made by special legal counsel, then authorization of indemnification and determination as to reasonableness of expenses must be made in the same manner.

(I) Non-exclusive. The indemnification provided by paragraphs 7.06(A) - 7.06(H) shall not be exclusive of any other rights to which a person may be entitled by law, bylaw, agreement, vote of the disinterested directors, or otherwise.

(J) Continuation. The indemnification and advance payment provided by paragraphs 7.06(A) - 7.06(H) shall continue as to a person who has ceased to hold a position named in paragraph 7.06(A), and shall inure to his heirs, executors and administrators.

(K) Insurance. The association may purchase and maintain insurance on behalf of any person who holds, or who has held, any position named in paragraph 7.06(A) against any liability incurred by him in any such position, or arising out of his status as such, whether or not the association would have power to indemnify him against such liability under paragraphs 7.06(A) - 7.06(H).

(L) Limitation of Indemnification. A person may be indemnified under 7.06(C) of this article against judgments, penalties (including excise and similar taxes), fines, settlements and reasonable expenses incurred by the person in connection with the proceeding; but if the proceeding was brought by or in behalf

of the association, the indemnification is limited to reasonable expenses actually incurred by the person in connection with the proceeding.

(M) Indemnification Where Director, et. al. Prevails. The association shall indemnify a director, officer, agent or employee [or other person described in 7.06(A)] against reasonable expenses incurred by him in connection with a proceeding in which he is a named defendant or respondent because of his association with the association as described in 7.06(A) if he has been wholly successful, on the merits or otherwise, in the defense of the proceedings.

7.07 Resignation. A director, committee member, officer or agent may resign by giving written notice to the president or the secretary. The resignation shall take effect at the time specified in it, or immediately, if no time is specified. Unless it specifies otherwise, a resignation takes effect without being accepted.

7.08 Amendment of Bylaws.

(A) These Bylaws may be altered, amended or repealed at any meeting of the Board of Directors at which a quorum is present, by the affirmative vote of a majority of the directors present at such meeting, if notice of the proposed alteration, amendment or repeal is contained in the notice of the meeting.

(B) These Bylaws may also be altered, amended or repealed at any meeting of the association at which a quorum is present or represented, by the affirmative vote of a majority of the members present or represented at the meeting and entitled to vote thereat, if notice of the proposed alteration, amendment or repeal is contained in the notice of the meeting.

7.09 Construction. Whenever the context so requires, the masculine shall include the feminine and neuter, and the singular shall include the plural, and conversely. If any portion of these Bylaws shall be invalid or inoperative, then so far as is reasonable and possible:

(A) the remainder of these Bylaws shall be considered valid and operative; and

(B) effect shall be given to the intent manifested by the portion held invalid or inoperative.

7.10 Headings. The headings are for organization, convenience, and clarity. In interpreting these Bylaws, they shall be subordinated in importance to the other written material.

7.11 Relation to Articles of Incorporation. These Bylaws are subject to, and governed by, the Articles of Incorporation.

Anita W. Beaton
Vice President

Carole L. Lieu
Secretary

CONSENT OF DIRECTORS

OF

NATIONAL BUSINESS ASSOCIATION, INC.
a Missouri general not for profit corporation

January 2, 1991

* *

THE UNDERSIGNED, being a majority of the duly elected and acting Directors of NATIONAL BUSINESS ASSOCIATION, INC., (the "Corporation") acting pursuant to the provisions of the "General Not For Profit Corporation Law" of the State of Missouri, do hereby consent to the adoption of the following resolutions to-wit:

> RESOLVED, that Section 2.02 of Article II of the Bylaws of the Corporation is hereby amended to read in its entirety as set forth in Exhibit "A" attached hereto.

IN WITNESS WHEREOF, the undersigned Directors have executed this Consent effective as of the date and year first written above.

DIRECTORS:

MARTIN WALSH

ROBERT ALLEN

ANITA BEATY

PAT ARCHIBALD

AMENDMENT TO BYLAWS

OF

NATIONAL BUSINESS ASSOCIATION, INC.

A General Not For Profit Missouri Corporation

* *

This Amendment to the Bylaws of National Business Association, Inc., a general not for profit Missouri corporation, was duly adopted at a Board of Directors meeting held on the 2nd day of January 1991, as follows:

I.

Article II, Section 2.02 of the Bylaws of National Business Association is hereby amended to read as follows:

"2.02 Annual Meetings. Annual meetings of members, commencing with the year of 1991, shall be held on the first Tuesday in January in each year, if not a legal holiday, and if a legal holiday, then on the next secular day following, at 10:00 a.m. on which they shall elect, by plurality vote, a Board of Directors and transact such other business as may properly be brought before the meeting. Any member who wishes to properly bring a matter before any meeting shall, by written notice received by the Association at least sixty (60) days prior to the date for the Annual Meeting, request that the matter be brought before the Annual Meeting. Any action taken at any Annual Meeting of members with respect to a matter brought before the meeting by a member who failed to provide such written notice to the Association shall be null and void.

In the Notice of Annual Meeting, the Board of Directors shall recommend a slate of directors to fill the term of any directors whose terms have expired. Any member, at least sixty (60) days prior to the notice date for the Annual Meeting may, by written notice to the Association, request that any member of the Association be nominated as a director. The Notice of Annual Meeting shall include any nomination from the membership and such nominee shall be eligible for election at the Annual Meeting.

II.

Except as specifically amended hereby, the Bylaws of National Business Association remain in full force and effect as to all their terms and conditions.

This Amendment to the Bylaws was executed as of the 2nd day of January 1991.

NATIONAL BUSINESS ASSOCIATION

By: Robert G. Allen
ROBERT G. ALLEN, President

ATTEST:

Anita Beatty
_____, Secretary

Unamious Consent of Directors
of

NATIONAL BUSINESS ASSOCIATION
a Missouri Non-Profit Corporation

In Lieu of Special Meeting
Effective as of November 30, 1992

The undersigned, constituting all the duly elected Directors of National Business Association, a Missouri nonprofit corporation (the "Association"), do hereby unanimously consent to the adoption of the following resolutions as and for the act of the directors of the Association, to have the same force and effect as if adopted by unanimous vote at a duly called special meeting of the directors of the Association, at which all of the directors were present and voted:

AMENDMENT OF BYLAWS

WHEREAS, the board of directors desires to amend Article II, Section 2.02 of the bylaws of the Association in the manner provided below.

NO THEREFORE, BE IT RESOLVED that Article II, Section 2.02 of the Bylaws of the Association is hereby amended to read in its entirety as follows:

> 2.02 Annual Meetings. Annual meetings of the members of the association, commencing with the year of 1993, shall be held each year during the month of January, on a date to be determined each year by the Board of Directors of the association in its sole discretion, provided that the association shall give at least ten (10) days prior written notice of the meeting to the members in accordance with Section 2.04 of Article II of these Bylaws. At each annual meeting of the members of the association, the members shall elect, by a plurality vote, directors of the association, and transact such other business as may be properly brought before the meeting. In the Notice of the Annual Meeting, the Board of Directors shall recommend a slate of directors to fill the term of any directors whose terms have expired. Any member, at least sixty (60) days prior to the notice date of the Annual Meeting may, by written notice to the association, request that any member of the Annual Meeting shall include any nomination from the membership and such nominee shall be eligible for election at the Annual Meeting.

GROUP INSURANCE POLICIES

WHEREAS, the Board of Directors of the Association has reviewed certain contracts of group insurance providing coverage for losses resulting from accident or sickness, (the "Group Policy Contracts") submitted for its consideration by American National Insurance Company, a Texas corporation, and American National Life Insurance Company of Texas, a Texas corporation, and desires to contract with such companies to allow members of the Association the opportunity to apply for, and, to the extent to which such members are eligible for coverage under the terms and conditions of such policies, to obtain coverage thereunder through the issuance of individual certificates of coverage.

NOW THEREFORE, BE IT RESOLVED that the President of the Corporation, shall be and he hereby is authorized, empowered, and directed to enter into, and to execute the Group Policy Contracts on behalf of the Association, and to take such action as he may, at his sole and exclusive discretion, deem necessary or advisable to effectuate the purposes and intent of the foregoing resolutions, and that all acts undertaken or to be undertaken in connection therewith by such officer be, and the same hereby are, ratified, approved, confirmed, and adopted as acts and deeds of the Corporation.

AMENDMENT TO MANAGEMENT AGREEMENT

WHEREAS, the Board of Directors of the Association has entered into that certain Management Agreement (the "Management Agreement") with Customized Association Management Company ("CAMCO"), a Texas corporation, pursuant to which the Association has authorized CAMCO to manage the affairs of the Association;

WHEREAS, the Association and CAMCO desire to enter into that certain Amendment to Marketing Agreement (the "Amendment"), pursuant to which Section 2 of the Marketing Agreement will be amended as attached.

WHEREAS, the Board of Directors of the Association deems it in the best interests of the Association to execute and deliver the Amendment and to perform and consummate the transactions contemplated thereby.

NOW THEREFORE, BE IT RESOLVED that the Board of Directors of the Association does hereby ratify, confirm and adopt the execution of the Management Agreement as the act and deed of the Association.

FURTHER RESOLVED, that the President of the Corporation, shall be and he hereby is authorized, empowered, and directed to enter into, and to execute the Amendment on behalf of the Association, and to take such action as he may, at his sole and exclusive discretion, deem necessary or advisable to effectuate the purposes and intent of the foregoing resolutions, and that all acts undertaken or to be undertaken in connection therewith by such officer be, and the same hereby are, ratified, approved, confirmed, and adopted as acts and deeds of the Corporation.

RATIFICATION OF LEASE

WHEREAS, pursuant to the authority granted it by the Association under the Marketing Agreement, CAMCO has entered into that certain Office Lease Agreement (the "Lease"), for and on behalf of the Association, between CAMCO, as lessee, and Natron Limited Partnership, Metro KLS, Inc., as lessor, with respect to the premises located at 5025 Arapaho Road, Suite 515, Dallas, Texas 75248:

WHEREAS, the Board of Directors desires to ratify and confirm its obligations under the Lease.

NOW THEREFORE, BE IT RESOLVED that the Board of Directors of the Association does hereby ratify, confirm and adopt the execution of the Lease by CAMCO as the act and deed of the Association.

IN WITNESS WHEREOF, the undersigned directors of the Association have executed this consent effective as of the date and year first written above.

DIRECTORS:

Patrick Archibald

Dated: 11-30-92

Martin Walsh

Dated: 30 Nov 92

Robert Allen

Dated: 30 Nov 92

AMENDMENT
TO
BYLAWS
OF
NATIONAL BUSINESS ASSOCIATION

A General Not For Profit Missouri Corporation

This Amendment to the Bylaws of National Business Association, a general not for profit Missouri corporation, was duly adopted at a Board of Directors meeting held on the 4th day of April 1988, as follows:

I.

Article III, Section 1 of the Bylaws of National Business Association is hereby amended to read as follows:

> **"SECTION 1. CLASSES OF MEMBERS.** Members may be divided into such classes as shall be determined by the Board of Directors. All members shall be, directly or indirectly, associated or affiliated with small business enterprises or have business relationships with small business enterprises."

II.

Except as specifically amended hereby, the Bylaws of National Business Association remain in full force and effect as to all their terms and conditions.

This Amendment to the Bylaws was executed as of the 4th day of April 1988.

NATIONAL BUSINESS ASSOCIATION

By: Pat Archibald
PAT ARCHIBALD, President

ATTEST:

Jan Daniell
JAN DANIELL, Secretary

STATE OF MISSOURI

ROY D. BLUNT
SECRETARY OF STATE

CORPORATION DIVISION

CERTIFICATE OF CORPORATE GOOD STANDING

I, ROY D. BLUNT, SECRETARY OF STATE OF THE STATE OF MISSOURI, DO HEREBY CERTIFY THAT THE RECORDS IN MY OFFICE AND IN MY CARE AND CUSTODY REVEAL THAT

NATIONAL BUSINESS ASSOCIATION, INC.

WAS INCORPORATED UNDER THE LAWS OF THIS STATE ON THE 27TH DAY OF AUGUST, 1982, AND IS IN GOOD STANDING, HAVING FULLY COMPLIED WITH ALL REQUIREMENTS OF THIS OFFICE.

IN TESTIMONY WHEREOF, I HAVE SET MY HAND AND IMPRINTED THE GREAT SEAL OF THE STATE OF MISSOURI, ON THIS, THE 13TH DAY OF AUGUST, 1992.

Roy D. Blunt
Secretary of State

State of Missouri . . . Office of Secretary of State

ROY D. BLUNT, Secretary of State

Articles of Amendment to the Articles of Incorporation of a General Not For Profit Corporation

(To be submitted in duplicate by an attorney.)

HONORABLE ROY D. BLUNT
SECRETARY OF STATE
STATE OF MISSOURI
P.O. BOX 778
JEFFERSON CITY, MO 65102

The undersigned corporation, for the purpose of amending its Articles of Incorporation and pursuant to the provisions of the General Not For Profit Corporation Law" of the State of Missouri, hereby executes the following Articles of Amendment:

1. The name of the corporation is NATIONAL BUSINESS ASSOCIATION

2. There are NO (Insert "no" or "some") members, having voting rights with respect to amendments:

(Strike paragraphs (a), (b) or (c) when not applicable)

3. (X) (a) At a meeting of members, at which a quorum was present, held on _____, 19____, same receiving at least two-thirds (2/3) of the votes entitled to be cast by the members of the corporation present or represented by proxy at such meeting, the following amendments were adopted.

( ) (b) By a consent in writing signed by two-thirds (2/3) of all the members of the corporation entitled to vote with respect hereto, the following amendments were adopted:

( ) (c) At a meeting of directors (members having no voting rights with respect to amendments) held on April 4, 19 88, same receiving the votes of a majority of the directors then in office, the following amendment or amendments were adopted:

4. Article number 5 is amended to read as follows:

To provide a forum between businesses and families that includes information and group services in the area of health, education and lifestyle management as well as any activity permitted under the Missouri Not For Profit Corporation Act.

No. N00028113

STATE OF MISSOURI

ROY D. BLUNT, Secretary of State

CORPORATION DIVISION

Certificate of Amendment of a General Not For Profit Corporation

WHEREAS, NATIONAL BUSINESS ASSOCIATION, INC. (FORMERLY: HEALTH THROUGH EXERCISE ASSOCIATION)

a corporation organized under The General Not For Profit Corporation Law of Missouri has delivered to me duplicate originals of Articles of Amendment of its Articles of Incorporation and has in all respects complied with the requirements of law governing the amendment of Articles of Incorporation under The General Not For Profit Corporation Law of Missouri.

NOW, THEREFORE, I, ROY D. BLUNT, Secretary of State of the State of Missouri, do hereby certify that I have filed said Articles of Amendment as provided by law, and that the Articles of Incorporation of said corporation are amended in accordance therewith.

IN TESTIMONY WHEREOF, I hereunto set my hand and affix the GREAT SEAL of the State of Missouri. Done at the City of Jefferson, this 5th day of January, 1988.

Roy D. Blunt
Secretary of State

Fee $ 5.00

Corp. #7 (5-86)

State of Missouri . . . Office of Secretary of State

ROY D. BLUNT, Secretary of State

Articles of Amendment to the Articles of Incorporation of a General Not For Profit Corporation

(To be submitted in duplicate by an attorney.)

HONORABLE ROY D. BLUNT
SECRETARY OF STATE
STATE OF MISSOURI
P.O. BOX 778
JEFFERSON CITY, MO 65102

The undersigned corporation, for the purpose of amending its Articles of Incorporation and pursuant to the provisions of the "General Not For Profit Corporation Law" of the State of Missouri, hereby executes the following Articles of Amendment:

1. The name of the corporation is Health Through Exercise Association

2. There are No (Insert "no" or "some") members, having voting rights with respect to amendments;

(Strike paragraphs (a), (b) or (c) when not applicable)

3. (a) At a meeting of members, at which a quorum was present, held on _____, 19____, same receiving at least two-thirds (2/3) of the votes entitled to be cast by the members of the corporation present or represented by proxy at such meeting, the following amendments were adopted.

(b) By a consent in writing signed by two-thirds (2/3) of all the members of the corporation entitled to vote with respect thereto, the following amendments were adopted;

(c) At a meeting of directors (members having no voting rights with respect to amendments) held on December 18, 1987, same receiving the votes of a majority of the directors then in office, the following amendment or amendments were adopted;

4. Article number 1 is amended to read as follows:

"The name of the corporation is the National Business Association, Inc."

Corp. #54 (7-85)

(Over)

IN WITNESS WHEREOF, the undersigned corporation has caused these Articles of Amendment to be executed in i name by its President or Vice President, and its Secretary or Assistant Secretary, this 18th day of December, 1987.

CORPORATE SEAL
(If no seal, state "None")

NONE

HEALTH THROUGH EXERCISE ASSOCIATION
(Exact Corporate Title)

By Melissa C. Medlock
Its President or Vice-President

By Susan J. Turney
Its Secretary ~~or Assistant Secretary~~

State of ARKANSAS
County of PULAKSI } ss

I, Nancy A. Crase, a Notary Public, do hereby certify tha on the 18th day of Decmeber, 1987, Melissa C. Medlock (Acknowledgement by either officer is sufficient) personally appeared before me and being first duly sworn by me, acknowledged that she ~~he~~ signed as his free act and deed the foregoing document in the capacity therein set forth and declared that the statements therein contained are true, to his knowledge and belief.

IN WITNESS WHEREOF, I have hereunto set my hand and seal the day and year before written.

(NOTARIAL SEAL)

Nancy A Crase
Notary Public

My commission expires 11-1-90

State of Missouri . . . Office of Secretary of State

JAMES C. KIRKPATRICK, Secretary of State

CORPORATION DIVISION

ARTICLES OF INCORPORATION OF A GENERAL NOT FOR PROFIT CORPORATION

(To be submitted in duplicate by an attorney or

FILED AND CERTIFICATE OF INCORPORATION ISSUED

HONORABLE JAMES C. KIRKPATRICK FILING FEE $10.00
SECRETARY OF STATE
P.O. BOX 778
JEFFERSON CITY, MISSOURI 65102

AUG 27 1982

James C. Kirkpatrick

We, the undersigned,

(Not less than three)

Type or Print Name	Number	Street	City	State	Zip
Dale D. Turvey	1454	Chandellay	St. Louis	Missouri	63141
F. C. Schumacher,Jr	3	Sunnymead	St. Louis	Missouri	63124
Susan J. Turvey	1454	Chandellay	St. Louis	Missouri	63141

being natural persons of the age of eighteen years or more and citizens of the United States, for the purpose of forming a corporation under the "General Not For Profit Corporation Law" of the State of Missouri, do hereby adopt the following Articles of Incorporation:

1. The name of the corporation is: Health Through Exercise Association

2. The period of duration of the corporation is: perpetual
(Please state "perpetual" or a definite number of years)

3. The address of its initial Registered Office in the State of Missouri is:

4236 Lindell Blvd. (City) St. Louis Missouri (Zip) 63108 and

the name of its initial Registered Agent at said Address is: Dale D. Turvey

4. The first Board of Directors shall be 3 (At least three required) in number, their names and addresses being as follows:

Type or Print Name	Number	Street	City	State	Zip
Dale D. Turvey	1454	Chandellay	St. Louis	Missouri	63141
F. C. Schumacher,Jr.	3	Sunnymead	St. Louis	Missouri	63124
Susan J. Turvey	1454	Chandellay	St. Louis	Missouri	63141

5. The purpose or purposes for which the corporation is organized are:

To create anawareness of the fundamentals of health and physical fitness through support groups and seminars; to cesearch and evaluate new and existing health programs and diets; to publish a monthly tabloid on contemporary health issues as well as any activity permitted under the Missouri Not For Profit Corporation Act.

(NOTE: Any special provision authorized or permitted by Statute to be contained in the Articles of Incorporation may be inserted above.)

(INCORPORATORS MUST SIGN BELOW)

Dale Turvey
F Carl A C
Susan J. Turvey

} Incorporators

VERIFICATION

STATE OF Missouri
County of St. Louis } ss.

I, Rosetta E. Weintraub, a Notary Public, do hereby certify that on the

25th day of August, 19 82

Dale D. Turvey, F. C. Schumacher, Jr., Susan J. Turvey
Type or Print (Names of Incorporators)

personally appeared before me and being first duly sworn by me severally acknowledged that they signed as their free act and deed the foregoing document in the respective capacities therein set forth and declared that the statements therein contained are true, to their best knowledge and belief.

IN WITNESS WHEREOF, I have hereunto set my hand and seal the day and year above written.

Rosetta E. Weintraub
(Notary Public)

NOTARIAL SEAL

ROSETTA E. WEINTRAUB
NOTARY PUBLIC, STATE OF MISSOURI
MY COMMISSION EXPIRES 4/12/86
ST. LOUIS COUNTY

My commission expires:

FILED AND CERTIFICATE OF INCORPORATION ISSUED

THIS FIRST AMENDMENT TO THE AGREEMENT made and entered into at Vicksburg, Mississippi, on this the 30th of November, 1998 amending and restating that agreement entered into on November 3, 1989 by and between The National Business Association, a Missouri Non-Profit Corporation, (herein referred to as "Trustor or " the Association"), and such members of National Business Association who desire to participate under this agreement subsequent to its execution (herein referred to as "Participating Members"); Trustmark National Bank (hereinunder referred to as "Trustee"); and American National Life Insurance Company of Texas, (hereinafter referred to as the "Administrator").

WITNESSETH

The Administrator serves in the same capacity under the Trust created by the Trustor on November 3, 1989. Under the controlling Trust Agreement, upon notice of intended resignation by the Trustee, the Administrator is empowered to appoint a Successor Trustee. Such notice has been received by the Administrator and the Administrator is naming Merchants Bank as Successor Trustee.

The Trustor is interested in providing group insurance programs for members of the Association who become eligible to participate in such programs (hereinafter referred to as "Participating Members"). It is the purpose of the Trustor, to that end, to create this Trust. The Administrator shall provide the management and administration of the insurance program for the Trustor and Participating Members.

The Trustee will be the named Policyholder of all insurance contracts and the Trustee shall have no administrative functions and responsibilities, with respect to such contracts other than to hold such contracts and, at the direction of the Trustor, attach various documents to the contracts. All other administrative functions and responsibilities are delegated to and assumed by the Administrator.

American National Life Insurance Company of Texas is qualified to administer group insurance programs, has agreed to act as Administrator of the insurance programs contemplated by this Trust, and said Company is hereby appointed Administrator by the Trustor.

NOW THEREFORE, in consideration of the promises and mutual covenants and conditions hereinafter contained, the parties agree as follows:

1. The Trustor shall from time to time, provide applications on behalf of the Trustee (as Policyholder) to the insurer for an insurance contract or contracts providing Group Life, Health, Disability or Dental insurance that will provide benefits for the Participating Members who are accepted by the insurer, in such amounts and subject to such conditions as the Trustor shall determine.

2. The Administrator shall receive applications for insurance coverage under the group insurance contracts, collect premiums, deposit funds without liability to invest or pay interest theron, make payments as required and perform any and all functions as may be necessary for the administration of the insurance programs.

3. The Trustee shall not assume any responsibility nor be liable for collection, remittance, forwarding or payment of premium for the Trust or its Participating Members or for the continuation of the coverage, or application for or obtaining renewals thereof, or replacement of same in the event of cancellation or termination thereof, nor shall it have any duties or responsibilites with respect to the payment, settlement, processing or presentment of claims.

4. All correspondence and monies that the Trustee may receive shall be promptly turned over to the Administrator at its home office in Galveston, Texas.

5. All premiums shall be paid directly to the Administrator, and neither the Trustee nor the Trustor shall have any responsibilities hereunder, except that the Trustee shall act as holder of the insurance group contracts, shall sign such applications as may be prepared by the Trustor, and shall act as policy owner for all such group insurance contracts.

6. The Trustor is not authorized to incur any expense or obligation on the part of the Participating Members or the Trustee in connection with the administration of the insurance programs.

7. There shall be no obligation, direct or implied, upon any Participating Member of this Trust arising out of this agreement, except for the payment of premium for insurance.

8. This Trust Agreement shall terminate one hundred (100) days after the termination date of the last insurance policy held by the Trust.

9. Trustor agrees to pay the Trustee a mutually agreed upon annual fee for each calendar year or portion thereof that this Trust Agreement is in force, in consideration of the services rendered by the Trustee pursuant to this Agreement. Administrator agrees to reimburse the Trustee for any court costs and reasonable attorney's fees in the event that the Trustee is a party to litigation directly related to this Agreement or in the event Trustee reasonably feels that it should consult legal counsel regarding Trustee powers and duties pursuant to this Agreement.

10. The Administrator hereby agrees to prepare and file all tax or information returns, Federal, State, or local, that may now or hereafter be required in connection with the insurance contracts held by the Trustee, and further agrees to prepare and file all documents or forms that may now or hereafter be required by law.

11. In the event the Trustee resigns or is otherwise unable or unwilling to act as Trustee, the Administrator, as agent of the Participating Members of said Trust, shall appoint a Successor Trustee.

12. The Trustee or any successor in trust may resign by mailing by registered mail, written notice thereof to the Administrator not less than thirty (30) days prior to the effective date of such resignation. Upon receipt of such a notice, the Administrator may appoint a successor immediately.

13. Each Successor Trustee appointed hereunder shall have the same rights, immunities, and duties conferred or imposed herein upon the Trustee, provided, however, that a successor or successors in trust shall not be liable for acts or neglect of any predecessor trustee.

14. The Administrator hereby agrees to defend, indemnify and hold the Trustee harmless of and from any and all claims or demands made or brought against the Trustee by any person, firm, corporation, or group arising out of its acting as Trustee hereunder, and from and against any losses, damages, costs, fees and expenses the Trustee may incurr or sustain in connection therewith, and to save the Trustee free of and from any such liability whatsoever as it relates to this Trust Agreement.

15. Relationship of Trust to Federal Law: This Trust is not intended to constitute an "employee benefit plane as that term is used in the Employee Retirement Income Security Act of 1974 ("ERISA"). The parties enter into this Agreement solely for the purpose of satisfying State Group benefit laws and the participating members recognize that each of them must determine the applicability of ERISA to any programs they may purchase through this Trust. Responsibility for compliance with ERISA as it may apply to the program purchased by any Participating Member rests with the Participating Member, although the Administrator will ensure that the rules of ERISA with regard to the marketing of products are obeyed. Upon request by a Participating Member, the Administrator will request the providers of benefits to provide such data as may be necessary to enable each Participating Member to which ERISA applies to comply with ERISA's reporting and disclosure obligations.

16. This Trust Agreement is executed under the Laws of the State of Mississippi and the laws of that state shall control in determining the validity, meaning, effect and enforcement thereof.

17. Administrator agrees and is hereby obligated to comply and conform with all applicable laws and regulations imposed by the State of Mississippi and other states in which individuals may be covered by insurance contracts issued hereunder

IN WITNESS WHEREOF, the parties hereto have hereunto set their hands and seals the day and year noted.

("Trustor")

National Business Association, Inc.

By: _____

Title: President

Dated: 11-9-98

("Sucessor Trustee")

Merchants Bank

By: _____

Title: V.P. & Trust Officer

Dated: 11-25-98

CONSENT OF ADMINISTRATOR

American National Life Insurance Company of Texas has been appointed by the Trustor to act as administrator and hereby consents to do so in accordance with the Trust Agreement attached hereto.

By: _____

Title: Vice President

Dated: 11/9/98

THIS AGREEMENT, made and entered into at Jackson, Mississippi, on the ~~1st~~ 3RD of ~~January, 1990~~ December 1989, by and between The National Business Association, a Missouri Non-Profit Corporation, (herein referred to as "Trustor" or "the Association"), and such members of National Business Association who desire to participate under this agreement subsequent to its execution (herein referred to as "Participating Members"); Trustmark National Bank (hereinunder referred to as "Trustee"); and American National Life Insurance Company of Texas, (hereinafter referred to as the "Administrator").

WITNESSETH

The Trustor is interested in providing group insurance programs for members of the Association who become eligible to participate in such programs (hereinafter referred to as "Participating Members"). It is the purpose of the Trustor, to that end, to create this Trust. The Administrator shall provide the management and administration of the insurance program for the Trustor and Participating Members.

The Trustee will be custodian, owner, and holder of all insurance contracts and neither the Trustee nor the Trustor hereof will have any administrative functions and responsibilities, with respect to such contracts, such responsibilities and functions being delegated to and assumed by the Administrator.

The Trustee has agreed to accept such trust arrangement and to act as custodian, owner, and holder of the insurance contracts subject to the conditions and limitations hereinafter set forth.

American National Life Insurance Company of Texas is qualified to administer group insurance programs, has agreed to act as Administrator of the insurance programs contemplated by this Trust, and said Company is hereby appointed Administrator by the Trustor.

NOW THEREFORE, in consideration of the promises and mutual covenants and conditions hereinafter contained, the parties agree as follows:

1. The Trustor shall from time to time, provide applications on behalf of the Trustee (as policy owner) to the insurer for an insurance contract or contracts providing Group Life, Health, Disability or Dental insurance that will provide benefits for the Participating Members who are accepted by the insurer, in such amounts and subject to such conditions as the Trustor shall determine.

2. The Administrator shall receive applications for insurance coverage under the group insurance contracts, collect premiums, deposit funds without liability to invest or pay interest theron, make payments as required and perform any and all functions as may be necessary for the administration of the insurance programs.

3. The Trustee shall not assume any responsibility nor be liable for collection, remittance, forwarding or payment of premium for the Trust or its Participating Members or for the continuation of the coverage, or application for or obtaining renewals thereof, or replacement of same in the event of cancellation or termination thereof, nor shall it have any duties or responsibilites with respect to the payment, settlement, processing or presentment of claims.

4. All correspondence and monies that the Trustee may receive shall be promptly turned over to the Administrator at its home office in Galveston, Texas.

5. All premiums shall be paid directly to the Administrator, and neither the Trustee nor the Trustor shall have any responsibilities hereunder, except that the Trustee shall act as holder of the insurance group contracts, shall sign such applications as may be prepared by the Trustor, and shall act as policy owner for all such group insurance contracts.

6. The Trustor is not authorized to incur any expense or obligation on the part of the Participating Members or the Trustee in connection with the administration of the insurance programs.

7. There shall be no obligation, direct or implied, upon any Participating Member of this Trust arising out of this agreement, except for the payment of premium for insurance.

8. This Trust Agreement shall terminate one hundred (100) days after the termination date of the last insurance policy held by the Trust.

9. In consideration of the services rendered by the Trustee, the Administrator agrees to pay said Trustee a mutually agreed upon reasonable annual fee for each year that this Trust is in force and to reimburse the Trustee for all its expense, including court costs and reasonable attorney's fees in the event that the Trustee is a party to litigation, except as a result of its own acts, omissions or negligence, or in the event the Trustee reasonably feels it should consult legal counsel in connection with its powers or duties under this Trust.

10. The Administrator hereby agrees to prepare and file all tax or information returns, Federal, State, or local, that may now or hereafter be required in connection with the insurance contracts held by the Trustee, and further agrees to prepare and file all documents or forms that may now or hereafter be required by law.

11. In the event the Trustee resigns or is otherwise unable or unwilling to act as Trustee, the Administrator, as agent of the Participating Members of said Trust, shall appoint a Successor Trustee.

12. The Trustee or any successor in trust may resign by mailing by registered mail written notice thereof to the Administrator not less than sixty (60) days prior to the effective date of such resignation. Upon receipt of such a notice, the Administrator may appoint a successor immediately.

13. Each Successor Trustee appointed hereunder shall have the same rights, immunities, and duties conferred or imposed herein upon the Trustee, provided, however, that a successor or successors in trust shall not be liable for acts or neglect of any predecessor trustee.

14. The Administrator hereby agrees to defend and hold the Trustee harmless of and from any and all claims or demands made or brought against the Trustee by any person, firm, corporation, or group arising out of its undertaking to act as Trustee hereunder, other than the acts, omissions or negligence of the Trustee, and from and against any losses the Trustee may incur or sustain in connection with this Trust occasioned by an act, neglect, or misconduct of the Administrator, and to save the Trustee free of and from any such liability.

15. Relationship of Trust to Federal Law: This Trust is not intended to constitute an "employee benefit plan" as that term is used in the Employee Retirement Income Security Act of 1974 ("ERISA"). The parties enter into this Agreement solely for the purpose of satisfying State Group benefit laws and the participating members recognize that each of them must determine the applicability of ERISA to any programs they may purchase through this Trust. Responsibility for compliance with ERISA as it may apply to the program purchased by any Participating Member rests with the Participating Member, although the Administrator will ensure that the rules of ERISA with regard to the marketing of products are obeyed. Upon request by a Participating Member, the Administrator will request the providers of benefits to provide such data as may be necessary to enable each Participating Member to which ERISA applies to comply with ERISA's reporting and disclosure obligations.

16. This Trust Agreement is executed under the Laws of the State of Mississippi and the laws of that state shall control in determining the validity, meaning, effect and enforcement thereof.

IN WITNESS WHEREOF, the parties hereto have hereunto set their hands and seals the day and year noted.

("Trustor")
National Business Association

By: [signature] President (Title)

Dated: 11-3-89

("Trustee")
Trustmark National Bank

By: Robert T. Quarles Vice Pres. & TRUST OFFICER (Title)

Dated: 11-9-1989

CONSENT OF ADMINISTRATOR

American National Life Insurance Company of Texas has been appointed by the Trustor to act as administrator and hereby consents to do so in accordance with the Trust Agreement attached hereto.

By: [signature] Attorney (Title)

Dated: November 3, 1989

AMERICAN NATIONAL

AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS
HOME OFFICE: ONE MOODY PLAZA
GALVESTON, TEXAS 77550

ARKANSAS RIDER FOR CARE AND TREATMENT OF ALCOHOLISM OR DRUG DEPENDENCY

This Rider is issued as part of and subject to all the terms, conditions and provisions of the Policy and any Certificate to which it is attached.

In consideration of the payment of any additional premium, We will provide the coverage described in this Rider. We reserve the right to reduce such benefits to the extent that benefits are payable under the plan in the absence of coverage under this Rider.

The following amends the applicable provision:

Necessary care and treatment of alcoholism and drug dependency will be covered in an Alcohol and Drug Dependency Treatment Center or Hospital.

An Alcohol and Drug Dependency Treatment Center is a public or private facility or unit of a facility engaged in providing 24 hour treatment for substance abuse, and which provides a program for treatment of such abuse pursuant to a written treatment plan approved and monitored by a Physician, properly licensed or accredited by the Department of Human Services/Office on Alcohol and Drug Abuse Prevention.

The facility or unit may be: (a) within a hospital or attached to or be a freestanding unit of a general hospital or psychiatric hospital; or (b) a freestanding facility specializing in such treatment; but (c) will not include halfway houses or recovery farms.

Such treatment will be covered to a maximum of $6,000.00 for each 24 month period, that no more than $3,000.00 will be paid in any 30 consecutive day period. The lifetime maximum is $12,000.00 for the treatment and necessary care of alcohol or drug dependency.

This Rider takes effect and expires with the Policy and any Certificate to which it is attached. Nothing contained in this Rider will be held to change, waive or extend any provisions of the Policy/Certificate except as stated in this Rider. Rider date, if different from Certificate date.

Signed on behalf of American National Life Insurance Company of Texas.

The Policyholder does hereby: ☐ Accept ☑ Reject this Rider.

08/12/2009
Date

Signature

President
Title

J. Mark Flippin

Secretary

AMERICAN NATIONAL

AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS
HOME OFFICE: ONE MOODY PLAZA
GALVESTON, TEXAS 77550

ARKANSAS RIDER FOR HEARING AIDS

This Rider is issued as part of and subject to all the terms, conditions and provisions of the Policy and any Certificate to which it is attached.

In consideration of the payment of any additional premium, We will provide the coverage described in this Rider. We reserve the right to reduce such benefits to the extent that benefits are payable under the plan in the absence of coverage under this Rider.

Coverage for a hearing aid or hearing instrument, which is sold on or after January 1, 2010, by a professional licensed by the State of Arkansas to dispense a hearing aid or hearing instrument.

Such coverage:

1. will not be for less than $1,400.00 per ear for each three-year period; and
2. Will provide coverage of not less than $1,400 per ear beginning on the first day of coverage; and
3. will not be subject to any deductibles or copayment requirements.

For purposes of this benefit, a "hearing aid" is an instrument or device, including repair and replacement parts that is:

1. designed and offered for the purpose of aiding persons with or compensating for impaired hearing;
2. worn in or on the body; and
3. generally not useful to a person in the absence of a hearing impairment.

This Rider takes effect and expires with the Policy and any Certificate to which it is attached. Nothing contained in this Rider will be held to change, waive or extend any provisions of the Policy/Certificate except as stated in this Rider. Rider date, if different from Certificate date.

Signed on behalf of American National Life Insurance Company of Texas.

The Policyholder does hereby: ☐ Accept ☑ Reject this Rider.

08/12/2009
Date

Signature

President
Title

J. Mick Flippin

Secretary

AMERICAN NATIONAL

AMERICAN NATIONAL INSURANCE COMPANY OF TEXAS
HOME OFFICE: ONE MOODY PLAZA GALVESTON, TEXAS 77550

MENTAL ILLNESS TREATMENT RIDER

This Rider is part of the Group Policy and must be attached to the Certificate evidencing coverage under the Group Policy. This Rider applies to a Covered Person who is a resident of Arkansas on the Certificate Date and on the date a claim is incurred. This Rider is effective on the latter of the Certificate Date or the Effective Date shown below. This Rider is subject to all provisions, terms, definitions and limitations of the Group Policy, which are not in conflict with the provisions of this Rider.

If the Policyholder elects this Rider and a Covered Person incurs Reasonable and Customary Charges for the Medically Necessary care and treatment of mental illness, the benefits described in this Rider will be paid in lieu of those described in the Group Policy.

Eligible Expenses for such treatment will be covered as they would for any other Sickness subject to a-Co-Insurance Percentage of 80%, not to exceed a maximum of $7,500.00 per Calendar Year, as follows:

1. Inpatient confinement including partial hospitalization must be in a Hospital, psychiatric hospital, outpatient psychiatric center licensed by the State Health Department or a Community Mental Health Center certified by the Department of Human Services, Division of Mental Health Services

Partial hospitalization means continuous treatment for at least 4 hours but less than 16 hours in any 24 hour period.

2. Outpatient benefits will be provided for services furnished by:

(a) A Hospital, psychiatric hospital, outpatient psychiatric center licensed by the State Health Department or a Community Mental Health Center certified by the Department of Human Services, Division of Mental Health Services;

(b) A Doctor licensed under the Medical Practices Act;

(c) A licensed psychologist; and

(d) A Community Mental Health Center or other Mental Health Clinic certified by the Department of Human Services, Division of Mental Health Services.

Benefits payable under this Rider are subject to any co-payment, co-insurance, deductible or dollar limitation provisions of the Group Policy that are not inconsistent with this Rider.

Except as stated in this Rider, nothing contained in this Rider will be held to change, waive or extend any provisions of the Group Policy.

Coverage under this Rider begins on the date coverage under the Group Policy is effective or such later date as shown on the applicable endorsement to the Group Policy. All coverage under this Rider expires when coverage under the Group Policy expires, unless while coverage under he Group Policy is still in force:

1. ANTEX is notified in writing to terminate coverage under this Rider. In such case, termination and cessation of premium payment, if any, for this Rider will commence as of the next premium due date after ANTEX has received the written termination notification; or
2. A Covered Person(s) moves to a state other than Arkansas. In such case, termination of benefits payable under this Rider and cessation of premium payment, if any, for such Covered Person(s) will commence as of the next premium due date after the change of residency.

The Policyholder does hereby: ☐ Accept ☑ Reject this Rider.

08/12/2009
Date

Signature

President
Title

J. Mick Fliplin
Secretary

Form ANL-AR06OF

AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS
HOME OFFICE: ONE MOODY PLAZA
GALVESTON, TEXAS 77550

OPTIONAL RIDER FOR DIAGNOSIS AND TREATMENT OF MUSCULOSKELETAL DISORDERS

The following benefit is added to the Group Policy:

Charges for treatment of the bones and joints of the face, head and neck in the same manner as coverage for treatment of other bones and joints of the human body as defined under Arkansas House Bill 2363.

ANTEX will provide medically necessary diagnosis and treatment of musculoskeletal disorders affecting any bone or joint in the face, neck or head, including temporomandibular joint disorder and craniomandibular disorder whether the condition is the result of accident, trauma, congenital defect, developmental defect, or pathology. Treatment includes both surgical and nonsurgical procedures. Coverage will be on the same basis as that provided for any other musculoskeletal disorder in the body.

Rejection of this option means that benefits as provided by Arkansas House Bill 2363 will not be included in the Group Policy.

The Group Policyholder hereby: _____ Accepts ___✓___ Rejects the coverage of this Rider.

_____ Signed

08/12/2009 _____ Dated

Except as stated in this Amendment, nothing contained in this Amendment will be held to change, waive or extend any provisions of the Group Policy. This Amendment expires when coverage under the Group Policy expires.

Signed on behalf of American National Life Insurance Company of Texas at Galveston, Texas.

J. Mark Flippin

Secretary

AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS
HOME OFFICE: ONE MOODY PLAZA
GALVESTON, TEXAS 77550

ARKANSAS OPTIONAL RIDER FOR OUTPATIENT SERVICES

The following benefit is added to the Group Policy:

Eligible Expenses will include outpatient services for the following:

1. Laboratory and pathological tests;
2. X-rays;
3. Chemotherapy;
4. Radiation treatment; and
5. Renal dialysis.

The Group Policyholder hereby: _____ Accepts ✓ Rejects the coverage of this Rider.

Abby Nisankano Signed

08/12/2009 Dated

Except as stated in this Amendment, nothing contained in this Amendment will be held to change, waive or extend any provisions of the Group Policy. This Amendment expires when coverage under the Group Policy expires.

Signed on behalf of American National Life Insurance Company of Texas at Galveston, Texas.

J. Mick Ellis

Secretary

SERFF Tracking Number:	*ANTX-126249188*	*State:*	*Arkansas*
Filing Company:	*American National Life Insurance Company of Texas*	*State Tracking Number:*	*43144*
Company Tracking Number:			
TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15G.002 Large Group Only*
Product Name:	*NBA 09 AR*		
Project Name/Number:	*NBA 09 AR/*		

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
08/06/2009	Form	MASTER POLICY AMENDMENT ARKANSAS RESIDENTS	09/03/2009	MASTER POLICY AMENDMENT non HSA AR.pdf (Superceded)
08/06/2009	Form	Certificate	09/03/2009	ANL-C09-C.pdf (Superceded)

AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS
(Herein referred to as: ANTEX, the Company, We, Our or Us)
HOME OFFICE: ONE MOODY PLAZA
GALVESTON TEXAS

MASTER POLICY AMENDMENT ARKANSAS RESIDENTS

DEFINITIONS

The following definitions are revised:

COMPLICATIONS OF PREGNANCY means:

1. conditions, requiring Hospital confinement (when the pregnancy is not terminated), whose diagnosis are distinct from pregnancy, but are adversely affected by pregnancy or are caused by pregnancy, such as (1) acute nephritis; (2) nephrosis; (3) cardiac decompensation;(4) HELLP syndrome; (5) uterine rupture; (6) amniotic fluid embolism; (7) chorioamnionitis; (8) fatty liver in pregnancy; (9) septic abortion; (10) placenta accreta; (11) gestational hypertension; (12) puerperal sepsis; (13) peripartum cardiomyopathy; (14) cholestasis in pregnancy; (15) thrombocytopenia in pregnancy; (16) placenta previa; (17) placental abruption; (18) acute cholecystitis and pancreatitis in pregnancy; (19) postpartum hemmorrhage; (20) septic pelvic thromboplebitis; (21) retained placenta; (22) venous air embolus associated with pregnancy; (23) miscarriage; or (24) an emergency c-section required because of (a) fetal or maternal distress during labor, or (b) severe pre-eclampsia, or (c) arrest of descent or dilitation, or (d) obstruction of the birth canal by fibroids or ovarian tumors, or (e) necessary because of the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that, in the absence of immediate medical attention, will result in placing the life of the mother or fetus in jeopardy. A c-section delivery is not considered to be an emergency c-section if it is merely for the convenience of the patient and/or doctor or solely due to a previous c-section; and

2. Treatment, diagnosis or care for conditions, including the following, when the condition was caused by, necessary because of, or aggravated by the pregnancy: (1) hyperthyroidism, (2) hepatitis B 0r C, (3) HIV (4) Human papilloma virus, (5) abnormal PAP, (6) syphilis, (7) chlamydia, (8) herpes, (9) urinary tract infections, (10) thromboembolism, (11) appendicitis, (12) hypothyroidism, (13) pulmonary embolism, (14) sickle cell disease, (15) tuberculosis, (16) migraine headaches, (17) depression, (18) acute myocarditis, (19) asthma, (20) maternal cytomegalovirus, (21) urolithiasis, (22) DVT prophylaxis, (23) ovarian dermoid tumors, (24) biliary atresia and/or cirrhosis, (25) first trimester adnexal mass, (25) hyditidiform mole or (26) ectopic pregnancy.

PRE-EXISTING CONDITIONS means a disease or physical condition of a Covered Person, not otherwise excluded by name or specific description on the date of the Person's loss, which existed prior to the Covered Person's effective date under the Group Policy. Any exclusion or limitation applies only to a disease or physical condition for which medical advice or treatment was received by the Covered Person during the 12 months prior to the effective date of coverage under the Group Policy. In no event will the exclusion or limitation apply to loss incurred after the earlier of:

1. The end of a continuous period of 12 months commencing on or after the effective date of the Covered Person's coverage during all of which the Person received no advice or treatment in connection with such disease or physical condition; or
2. The end of the 2-year period commencing on the effective date of the Covered Person's effective date of coverage under the Group Policy.

MEDICAL SERVICES

Anesthesia Administration is changed to read:

Anesthesia Administration - Reasonable and Customary Charges for the administration of anesthesia by an anesthesiologist to a Covered Person undergoing surgery while Hospital Confined or in a Same Day Surgery Facility. The anesthesiologist must be at the operation solely to provide the anesthesia service.

We will reduce benefits otherwise payable had an anesthesiologist administered anesthesia by [50%] if a nurse anesthetist, operating Doctor, or assistant Surgeon administers the anesthesia, including any incidental fluids, as part of a covered surgical procedure. When both an anesthesiologist and a nurse anesthetist bill for the same operative session, benefits will be limited to the Reasonable and Customary charges otherwise payable had the anesthesiologist been the sole provider of such services.

Coverage includes charges incurred for those for services performed in connection with dental procedures in a Hospital or Ambulatory Surgical Center when the Doctor treating the Covered Person certifies that, because of the patient's age or condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the procedures and the Covered Person is: (1) a child under 7 years of age who is determined by two dentists licensed in Arkansas to require, without delay, necessary dental treatment in a Hospital or Ambulatory Surgical Center for a significantly complex dental condition; (2) a person with a diagnosed serious mental of physical condition; or (3) a person with a significant behavioral problem as determined by the Covered Person's Doctor. This benefit does not apply to services performed in connection with temporomandibular joint disorders.

The following **MEDICAL SERVICES** are added**:**

ARKANSAS RESIDENT BENEFITS – The following benefits apply only when described services are provided to a Covered Person who is an Arkansas resident. Except as otherwise stated, they are subject to all the terms and conditions of the Group Policy.

Newborn Infants – When the Certificate evidences coverage for persons in addition to You, and You have given Us notice of a newborn as required by Automatic Coverage of Newborn and Adopted Children, coverage will include the Reasonable and Customary Charges incurred for the Medically Necessary care and treatment of a newborn child, while the child is Hospital Confined, as follows: (a) coverage for Sickness or Injury, congenital defects, and premature birth; (b) coverage for tests for hypthyroidism, phenylketonuria, galactosemia, sickle-cell amenia, and all other disorders of metabolism for which screening is performed by or for the State of Arkansas, as well as any testing of newborn infants hereafter mandated by law; and (c) a minimum of 48 hours up to 5 full days of routine nursery care and pediatric charges for a well newborn in a Hospital nursery or until the mother is discharged from the Hospital following the birth of the child, whichever is the lesser period of time.

Speech and Hearing - Reasonable and Customary Charges incurred for necessary care and treatment of loss or impairment of speech or hearing while Hospital Confined. Coverage does not include hearing instruments or devices.

Colorectal Screening - Reasonable and Customary Charges for colorectal cancer examinations and laboratory tests, while Hospital Confined or in an Ambulatory Surgical Center, for: (1) Covered Persons who are 50 years of age or older; (2) Covered Persons who are less than 50 years of age and at a high risk for colorectal cancer; (3) Covered Persons experiencing the following symptoms: bleeding from the rectum or blood in the stool; a change in bowel habits, such as diarrhea, constipation, or narrowing of the stool, that lasts more than 5 days.

The colorectal screening will involve an examination of the entire colon, including the following exams or laboratory tests, or both:

1. An annual fecal immunochemical test in conjunction with a flexible sigmoidoscopy every 5 years;
2. A double-contrast barium enema every 5 years; or
3. A colonoscopy every 10 years; and
4. Any additional medically recognized screening tests for colorectal cancer required by the Director of the Department of Health.

Follow-up screenings are covered as follows:

1. If the initial colonoscopy is normal, follow-up is recommended in 10 years;
2. For Covered Persons with 1 or more neoplastic plyps, adenomatous polyps, assuming that the initial colonoscopy was complete to the cecum and adequate preparation and removal of all visualized polyps follow-up is recommended in 3 years;
3. If single tubular adenoma of less than 1 centimeter (4 for patients with large sessile adenomas greater than 3 centimeters) especially if removed in piecemeal fashion, follow-up is recommended in 6 months or until complete polyp removal is verified by colonoscopy.

Diabetes – Reasonable and Customary Charges for equipment, supplies, medication and a one per lifetime self-management training and patient management, including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin-using diabetes, while Hospital Confined. The self-management diabetes training program must be Medically Necessary as determined by a Doctor. Additional training is covered when a Doctor prescribes the additional training as Medically Necessary because of a significant change in the Covered Person's symptoms or conditions.

EXCEPTIONS

Number 11 is revised to state as follows:

11. A Pre-Existing Condition as defined in the Group Policy, except as stated under DEFINITIONS and TIME LIMIT ON CERTAIN DEFENSES, PRE-EXISTING CONDITIONS.

AUTOMATIC COVERAGE OF NEWBORN AND ADOPTED CHILDREN is revised as follows:

Newborns: If the Group Policy provides coverage for Covered Persons other than You, the Policy will also provide coverage for newborn children when they live with You from the moment of birth. This coverage is free for the first 90 days.

Adopted Children: If the Group Policy provides coverage for Covered Persons other than You, the Policy will also provide coverage for adopted children and children who are placed for adoption from the date of the filing of a petition for adoption. This coverage for adopted children is free for the first 60 days of the filing of a petition for adoption if You apply for coverage within 60 days after the filing of the petition for adoption. However, the coverage will be free for the first 60 days from the moment of birth if the petition for adoption and application for coverage is filed within 60 days after the birth of the minor.

In order to continue coverage for a newborn or adopted child, You must do the following:

1. Send Us notice of the child within the 90 days after the date of the child's birth or before the premium due date, whichever is later (or, in the case of an adopted child, within the 60 days after the filing of the petition for adoption or birth of child); and
2. Send Us the additional premium for the child within 90 days of the child's date of birth or within 60 days of the date of petition for adoption or birth of the child.

As long as You pay the extra premium, the child will remain a Covered Person, subject to the Termination of Coverage and Loss of Coverage Eligibility provisions of the Group Policy. Coverage for a child that is placed with You for adoption will continue in accordance with the Termination of Coverage and Loss of Coverage Eligibility provisions, unless the placement is disrupted prior to legal adoption and the child is removed from placement.

We do not require an application for the child unless You have notified Us of the child later than the timeframe as required above.

TERMINATION OF COVERAGE

The following paragraph is added:

If coverage under the Group Policy ends and is replaced by a group health insurance plan issued by another insurer or self-funded health care plan, coverage under the Group Policy will continue for any Covered Person who is Hospital Confined on the date coverage under the Group Policy ends. Continuation of such benefits are subject to all terms and conditions the Group Policy, except those relating to termination of benefits. Such benefits will continue until the Hospital Confinement ends or until the maximum benefits available under the Group Policy are paid, whichever occurs first.

LOSS OF ELIGIBILITY

The following sentence is added to the first paragraph:

If a Covered Person's coverage ends under the Group Policy, in accordance with the paragraphs above, such Person may be eligible for Continuation or Conversion. Please see the Conversion and Continuation Privilege.

EXTENSION OF COVERAGE FOR SOME CHILDREN

The entire section is deleted and replaced with the following:

When an unmarried dependent child who is a Covered Person has reached the Limiting Age, coverage may continue if the child is, and remains, incapable of sustaining employment by reason of mental retardation or physical disability and who is chiefly dependent upon the Certificateholder for support and maintenance.

ANTEX may ask the Certificateholder to furnish proof of the incapacity or dependency. ANTEX will bear the cost of obtaining such proof. The Certificateholder is expected to notify ANTEX if the incapacity or dependency is removed or terminated in the future.

The premium rate for the handicapped dependent will remain at the child rate.

TOTAL DISABILITY: "Total Disability" means a Covered Person's inability, because of Sickness or Injury, to perform the material and substantial duties of his/her occupation.

If a Covered Person suffers from Total Disability at the time of any termination or discontinuance of the Group Policy by ANTEX, regardless of the reason for the termination or discontinuance, ANTEX will provide an extension of benefits for a period of 12 months immediately following the date of termination or discontinuance. Benefits payable will be subject to the Group Policy's regular benefit limits.

GENERAL PROVISIONS

Under **TIME LIMIT ON CERTAIN DEFENSES,** the following is changed to read:

2. <u>PRE-EXISTING CONDITIONS</u>:
No claim for loss incurred after the earlier of: (a) the end of a continuous period of 12 months commencing on or after the Covered Person's effective date of coverage under the Group Policy, during which the Covered Person has received no medical advice or treatment in connection with such disease or physical condition or (b) the end of the 2-year period commencing on the effective date of the Covered Person's coverage under the Group Policy will be reduced or denied unless:

(a) The disease or physical condition has been excluded from coverage by name or specific description, and;
(b) Such exclusion is in effect on the date the loss is incurred.

TIME FOR PAYMENT OF CLAIMS is changed to read:

TIME FOR PAYMENT OF CLAIMS: We will pay or deny each Clean Claim as follows: (1) if the claim is filed electronically, within 30 days after the date We receive the claim; or (2) if the claim is filed on paper, within 45 days after the date we receive the claim. We will notify the claimant of any deficiencies in the claim not less than 30 days after the date We receive the claim. The notice will give an explanation of any additional information required. We will suspend

the claim until We receive the requested information. We will reopen and pay or deny the suspended claim within 30 days after We receive the information requested..

If We fail to pay or deny a Clean Claim or to give notice that We need more information to pay a claim, We will pay the claimant for the period beginning on the 61st day after receipt of the Clean Claim and ending on the Clean Claim payment date (this is called the delinquent payment period), calculated as follows: the amount of the Clean Claim payment times 12% per annum times the number of days in the delinquent payment period, divided by 365. We will pay this penalty without any action by the claimant.

A "Clean Claim" means a claim for payment of health care expenses that is submitted on a HCFA 1500 on a UB92 in a format required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), or on Our standard claim form with all required fields completed in accordance with Our published claim filing requirements. A Clean Claim does not include a claim (1) for payment of expenses incurred during a period of time for which premiums are delinquent; or (2) for which We need additional information in order to resolve the claim.

The following is added:

NOTICE TO CERTIFICATEHOLDERS: We are here to serve the Certificateholder. As our Certificateholder, Your satisfaction is very important to Us. If You have a question about Your Certificate, if You need assistance with a problem, or if You have a claim, You should first contact Your insurance agent or Us at 1-800-899-6520. If You do not have Your agent's name, address, or phone number, please contact Us and We will be able to supply the information.

If We at ANTEX fail to provide You with reasonable and adequate service, You should feel free to contact:

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, AR 72201-1904
1-800-852-5494

EXTERNAL REVIEW PROCEDURE – In certain cases, the Certificateholder has the right to request an External Review Procedure, as described in this Section.

The following terms are defined:

Adverse Determination means the Company's determination that an admission, availability of care, continued stay or other Medical Service has been reviewed and, based upon the information provided, the requested payment for the service is denied, reduced or terminated, because:

(a) The requested Health Care service does not meet the Company's requirements for Medical Necessity, or
(b) The requested Health Care service has been found to be "Experimental/Investigational."

In order to qualify as an "Adverse Determination:"

(a) The Adverse Determination must be a Final Adverse Determination, except as may be provided herein.
(b) The Adverse Determination must involve treatment, services, equipment, supplies, or drugs that would require the health benefit plan to expend five hundred dollars ($500) or more of expenditures.

Adverse Determination does not include the Company's determination to deny a Health Care service based upon:

(a) An express exclusion in the health benefit plan other than a general exclusion for "Medical Necessity" or "Experimental/Investigational;"
(b) An express limitation in the health benefit plan with respect to the number of visits, treatments, supplies or services for a covered benefit in a given calendar period or over the lifetime of the Covered Person;
(c) An express limitation in the health benefit plan with respect to a maximum dollar limitation with respect to a covered benefit in a given calendar period or over the lifetime of the Covered Person;
(d) The Company's determination that an individual is not eligible to be a Covered Person;
(e) The Company's determination that treatment, service, or supplies were requested or obtained by a Covered Person through fraud or material misrepresentation.

(f) The health benefit plan's procedure for determining the Covered Person's access to a Health Care Provider, including but not limited to a network access provision;
(g) Illegality of services or the means or methods of administering them;
(h) FDA or other government agency determinations, reports or statements; or
(i) Licensure, permit or accreditation status of a Health Care Provider.

Authorized Representative means:

(a) A person to whom a Covered Person has given express written consent to represent the Covered Person in an External Review;
(b) A person authorized by law to provide substituted consent for a Covered Person; or
(c) When the Covered Person is unable to provide consent, a family member of the Covered Person or the Covered Person's treating Health Care Professional if a family member is unavailable.

Commissioner means the Arkansas Insurance Commissioner.

Covered Benefits or Benefits means those Health Care services to which a Covered Person is entitled under the terms of a health benefit plan.

Covered Person means You. Covered Person shall also mean the Covered Person's Authorized Representative, as defined in this regulation.

Disclose means to release, transfer or otherwise divulge protected Health Information to any person other than the individual who is the subject of the protected Health Information.

Emergency Medical Condition means medical conditions of a recent onset and severity, including, but not limited to, severe pain that would lead a prudent lay person, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

Emergency Services means Health Care items and services furnished or required to evaluate and treat an Emergency Medical Condition.

External Review means a process, independent of all affected parties, to determine if a Health Care service is medically necessary or experimental/ investigational.

Facility means an institution providing Health Care services or a Health Care setting, including but not limited to, hospitals and other licensed inpatient centers, outpatient surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

Final Adverse Determination means an Adverse Determination involving a covered benefit that has been upheld by a health carrier at the completion of the health carrier's internal grievance procedure or Utilization Review procedure. If the health carrier does not have, nor is required by law to have, an internal grievance procedure or Utilization Review procedure, an Adverse Determination shall be considered a Final Adverse Determination.

Health care professional means a physician or other Health Care practitioner licensed, accredited or certified to perform specified health services consistent with state law.

Health Care Provider or Provider means a Health Care Professional or a Facility.

Health Care Services means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.

Health Information means information or data, whether oral or recorded in any form or medium, and personal facts or information about events or relationships that relates to:

(a) The past, present or future physical, mental, or behavioral health or condition of an individual or a member of the individual's family;
(b) The provision of Health Care services to an individual; or
(c) Payment for the provision of Health Care services to an individual.

Independent Review Organization means an entity that conducts independent External Reviews of Adverse Determinations and Final Adverse Determinations.

Medical or Scientific Evidence means the following sources:

(a) Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;
(b) Peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the National Institutes of Health's Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline and MEDLARS database Health Services Technology Assessment Research (HSTAR);
(c) Medical journals recognized by the Secretary of Health and Human Services under Section 1861(t)(2) of the federal Social Security Regulation;
(d) The following standard reference compendia: The American Hospital Formulary Service-Drug; The American Dental Association Accepted Dental Therapeutics; and The United States Pharmacopoeia-Drug Information;
(e) Findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including: The federal Agency for Healthcare Research and Quality; The National Institutes of Health; The National Cancer Institute; The National Academy of Sciences; The Centers for Medicare and Medicaid Services; Any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of Health Care services; and Any other Medical or Scientific Evidence that is comparable to the sources listed in Subparagraphs (a) through (e).

Medical or Scientific Evidence shall not include published peer-reviewed literature sponsored to a significant extent by a pharmaceutical manufacturing company or medical device manufacturer.

Medically Necessary or Medical Necessity has the same definition as found under the section of the Certificate titled **DEFINITIONS.**

Person means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, a limited liability company, any similar entity or any combination of the foregoing.

Protected Health Information means Health Information that is not subject to disclosure under state and/or federal law.

Retrospective Review means a review of Medical Necessity conducted after services have been provided to a patient, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication for payment.

Utilization Review and Utilization Review Procedure mean the system for reviewing the appropriate and efficient allocation of hospital resources and medical services given or proposed to be given to a patient or group of patients.

Requesting an External Review, General Information - At the time of an Adverse Determination or a Final Adverse Determination, the Company will notify the Covered Person and Health Care Professional in writing of the right to request an External Review.

Before filing a request for an External Review, a Covered Person must exhaust the Company's internal grievance procedures (unless the Company waives this requirement). A Covered Person has exhausted the internal grievance procedure when:

(a) The Covered Person has filed an appeal regarding an Adverse Determination with the Company; and
(b) The Covered Person has not received a written decision on the appeal from the Company within 30 days following the date the Covered Person filed the appeal. (This 30 day requirement does not apply if the Covered Person requested or agreed to a delay of the 30 day requirement); or
(c) The Covered Person has received a written decision regarding the appeal and the Company has made a Final Adverse Determination.

Once the Covered Person has received a Final Adverse Determination, the Covered Person has 60 days to request of External Review. The Covered Person must request an External Review in writing.

When requesting an External Review, the Covered Person will be required to authorize the release of any medical records that may be required for review in making the decision on the External Review. the Company will attach the authorization form to the External Review Notice.

A Covered Person has the right to contact the Commissioner for assistance with the External Review process at any time. The Commissioner's contact information is:

Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201
(501)371-2600 or 1-800-282-9134
insurance.Consumers@Arkansas.gov

Standard External Review – When the Company receives a request for an External Review, it will assign an Independent Review Organization (IRO) to the External Review.

The IRO will conduct a preliminary review to determine if:

(1) The request meets External Review requirements;
(2) The Covered Person has exhausted the Company's internal grievance process (unless the Covered Person is not required to exhaust the grievance process as described in this notice); and
(3) The Covered Person has provided all information and forms required to process an External Review, including the authorization form that the Company provided at the time of the Adverse or Final Adverse determination.

Within 5 business days, the IRO will review the Request and notify the Covered Person whether the request is complete and whether the IRO has accepted the Request. Within 7 business days after the date of receipt of this IRO notice, the Company will provide to the IRO, the Covered Person, and the Covered Person's treating Health Care Professional the documents and any information considered in making the Adverse Determination or Final Adverse Determination, together with any additional information required.

The IRO notice will include a statement that the Company, the Covered Person and the Covered Person's treating Health Care Professional may submit additional information and supporting documentation in writing to the IRO within 7 business days following the date of receipt of the notice. The IRO will consider this information when conducting the External Review. The IRO shall review all of the information and documents received in writing by the Covered Person, the Covered Person's treating Health Care Professional, and the Company.

If the request is not complete, the assigned IRO will, within 5 business days, inform the Company, the Covered Person, and the Covered Person's treating Health Care Professional what information or materials are needed to make the request complete. The IRO will immediately forward copies of any additional information to the Company.

If the request is not accepted for External Review, the assigned IRO will inform the Covered Person, the Covered Person's treating Health Care Professional and the Company in writing within 5 business days of the reasons for its nonacceptance.

In reaching a decision to accept or reject a matter for External Review, the IRO is not bound by any decisions or conclusions reached during the Company's internal grievance procedure or Utilization Review procedure.

Except in the case of the IRO terminating and reversing the Company's Adverse Determination or Final Adverse Determination because the Company failed to provide documents and information to the IRO within an acceptable time frame, failure by the Company or its Utilization Review organization to provide the documents and information within the time frame required will not delay the conduct of the External Review.

If the Company or its Utilization Review Organization fails to provide the documents and information within the time frame required, the IRO may terminate the External Review and make a decision to reverse the Adverse Determination or Final Adverse Determination.

Upon receipt of the information, if any, required to be forwarded to the IRO, the Company may reconsider its Adverse Determination or Final Adverse Determination that is the subject of the External Review.

Reconsideration by the Company of its Adverse Determination or Final Adverse Determination will not delay or terminate the External Review.

The External Review may only be terminated if the Company decides, upon completion of its reconsideration, to reverse its Adverse Determination or Final Adverse Determination and provide coverage or payment for the Health Care service that is the subject of the Adverse Determination or Final Adverse Determination.

Immediately upon making the decision to reverse its Adverse Determination or Final Adverse Determination, the Company shall notify the Covered Person, the Covered Person's treating Health Care Professional, and the IRO in writing of its decision.

The IRO will terminate the External Review upon receipt of the notice from the Company regarding its reversal.

In addition to the documents and information referred to above, the IRO, to the extent the information or documents are available and the IRO considers them appropriate, shall consider the following in reaching a decision:

(1) The Covered Person's medical records;
(2) The treating Health Care Professional's recommendation;
(3) Consulting reports from appropriate Health Care Professionals and other documents submitted by the health carrier, Covered Person, or the Covered Person's treating Health Care Professional;
(4) The most appropriate practice guidelines, which may include generally accepted practice guidelines, evidence-based practice guidelines or any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;
(5) Any applicable written screening procedures, decision abstracts, clinical protocols and practice guidelines used by a health carrier to determine the necessity and appropriateness of Health Care services;
(6) If the Adverse Determination involves a denial of coverage based on a determination that the recommended or requested Health Care services is "experimental" or "investigational," the IRO shall also consider whether:
    (a) The recommended or requested Health Care service or treatment has been approved by the federal Food and Drug Administration for the condition, while realizing that treatments or services are often legitimately used for purposes other than those listed in the FDA approval; or
    (b) Medical or scientific evidence demonstrates that the expected Benefits of the recommended or requested Health Care service or treatment is more likely than not to be more beneficial to the Covered Person than any available standard Health Care service or treatment and the adverse risks of the recommended or requested Health Care service or treatment would not be substantially increased over those of available standard Health Care services or treatments.

Within 45 calendar days after the date of receipt of the request for an External Review, the IRO shall provide written notice of its decision to uphold or reverse the Adverse Determination or the Final Adverse Determination to the Covered Person, the Covered Person's treating Health Care Professional, and the Company.

The IRO notice will include:
(a) A general description of the reason for the request for External Review;
(b) The date the IRO received the assignment from the health carrier to conduct the preliminary review of the External Review request;
(c) The date the External Review was conducted, if appropriate;
(d) The date of its decision;
(e) The principal reason or reasons for its decision;
(f) The rationale for its decision; and
(g) References to the evidence or documentation, including the practice guidelines, considered in reaching its decision.

If the Adverse Determination involves a denial of coverage based on a determination that the recommended or requested Health Care services is "experimental" or "investigational," the IRO shall also consider whether:

(i) A description of the indicators relevant to determining whether there is sufficient evidence to demonstrate that the recommended or requested Health Care service or treatment is more likely than not to be more beneficial to the Covered Person than any available standard Health Care services or treatments and the adverse risks of the recommended or requested Health Care service or treatment would not be substantially increased over those of available standard Health Care services or treatments; and

(ii) A description and analysis of any Medical or Scientific Evidence considered in reaching the opinion.

Upon receipt of a notice of a decision reversing the Adverse Determination or Final Adverse Determination, the Company will immediately approve the coverage that was the subject of the Adverse Determination or Final Adverse Determination.

The assignment by the Company of an approved IRO to conduct an External Review in accordance with this section shall be fair and impartial. the Company and the IRO shall comply with standards approved by the Commissioner to ensure fairness and impartiality in the assignment by health carriers of approved IRO to conduct External Reviews.

Expedited External Review – A Covered Person may make a request for an Expedited External Review at the time the Covered Person receives an Adverse Determination or a Final Adverse Determination.

The Covered Person may request an expedited External Review of an Adverse Determination if:

(a) The Covered Person has a medical condition where the timeframe for completion of an expedited review of an appeal set forth in the Company's internal grievance procedure or Utilization Review procedure would seriously jeopardize the life or health of the Covered Person or would jeopardize the Covered Person's ability to regain maximum function; or
(b) The Adverse Determination involves a denial of coverage based on a determination that the recommended or requested Health Care service or treatment is "experimental" or "investigational," and the Covered Person's treating physician certifies in writing that the recommended or requested Health Care service or treatment would be significantly less effective if not promptly initiated.

Note: A Covered Person may file a request for an expedited External Review at the same time the Covered Person files a request for an expedited review of an appeal under the Company's grievance or utilization review procedure if:

(a). The Covered Person has a medical condition where the timeframe for completion of an expedited review of an appeal set forth in the Company's internal grievance procedure or utilization review procedure would seriously jeopardize the life or health of the Covered Person or would jeopardize the Covered Person's ability to regain maximum function; or
(b). The Adverse Determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is "experimental" or "investigational," and the Covered Person's treating physician certifies in writing that the recommended or requested health care service or treatment would be significantly less effective if not promptly initiated.

The IRO will determine whether the Covered Person shall be required to complete the Company's expedited internal grievance procedure or Utilization Review procedure before it conducts the expedited External Review. Upon a determination that the Covered Person must first complete the expedited internal grievance review procedure or Utilization Review procedure, the IRO immediately shall notify the Covered Person and the Covered Person's treating Health Care Professional of this determination and that it will not proceed with the expedited External Review until the expedited internal grievance procedure or Utilization Review procedure is completed and the Adverse Determination or Final Adverse Determination is upheld.

The Covered Person may request an expedited External Review of a Final Adverse Determination if:

(a) The Covered Person has a medical condition where the timeframe for completion of a standard External Review would seriously jeopardize the life or health of the Covered Person, or would jeopardize the Covered Person's ability to regain maximum function; or
(b) The Final Adverse Determination concerns:

(i) An admission, availability of care, continued stay or Health Care service for which the Covered Person received Emergency Services, but has not been discharged from a Facility; or

(ii) A denial of coverage based on a determination that the recommended or requested Health Care service or treatment is experimental or investigational, and the Covered Person's treating physician certifies in writing that the recommended or requested Health Care service or treatment that is the subject of the request would be significantly less effective if not promptly initiated.

At the time the Covered Person makes a request for an expedited External Review, the Covered Person or the Covered Person's treating Health Care Professional shall submit additional information and supporting documentation that the IRO will consider when conducting the expedited External Review.

At the time the Company receives a request for an expedited External Review, the Company will immediately assign an IRO to the case.

At the time the Company assigns an IRO to conduct the expedited External Review, the Company shall immediately provide or transmit all documents and information considered in making the Adverse Determination or Final Adverse Determination, as well as any additional information and supporting documentation, to the IRO, the Covered Person, and the Covered Person's treating Health Care Professional via electronically, facsimile or any other available expeditious method.

The IRO will, as expeditiously as the Covered Person's medical condition or circumstances require, but in no event more than 72 hours after the date of receipt of the request for an acceptable expedited External Review:

(a) Make a decision to uphold or reverse the Adverse Determination or Final Adverse Determination; and
(b) Notify the Covered Person, the Covered Person's treating Health Care Professional, and the Company of the decision.

If the notice from the IRO was not in writing, within 2 days after the date of providing that notice, the IRO shall:

(a) Provide a written or electronic media confirmation of the decision to the Covered Person and the Company; and
(b) Include the information required for a Standard External Review Notice.

In reaching a decision, the IRO is not bound by any decisions or conclusions reached during the health carrier's Utilization Review process or the Company's internal grievance process.

Upon receipt of notice of a decision reversing the Adverse Determination or Final Adverse Determination, the Company will immediately approve the coverage that was the subject of the Adverse Determination or Final Adverse Determination.

An expedited External Review may not be provided for adverse or Final Adverse Determinations involving a Retrospective Review.

Binding Nature of External Review Decision -

(a) An External Review decision is binding on the Company except to the extent the Company has other remedies available under applicable federal or state law.

(b) An External Review decision is binding on the Covered Person except to the extent the Covered Person has other remedies available under applicable federal or state law.

(c) A Covered Person may not file a subsequent request for External Review involving the same Adverse Determination or Final Adverse Determination for which the Covered Person has already received an External Review decision pursuant to this regulation.

Filing Fees –

(a) Except in the case of a request for an expedited External Review, at the time of filing a request for External Review, the Covered Person shall submit to the IRO a filing fee of $25 along with the information and documentation to be used by the IRO in conducting the External Review.

(b) Upon application by the Covered Person, the Commissioner may waive the filing fee upon a showing of undue financial hardship.

(c) The filing fee shall be refunded to the person who paid the fee if the External Review results in the reversal, in whole or in part, of the Company's Adverse Determination or Final Adverse Determination that was the subject of the External Review.

(d) the Company against which a request for a standard External Review or an expedited External Review is filed shall pay the cost of the IRO for conducting the External Review.

This Amendment is signed on behalf of the Company.

Secretary

AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS

A Stock Life Insurance Company
HOME OFFICE: ONE MOODY PLAZA
GALVESTON, TEXAS 77550

GROUP HOSPITAL INSURANCE CERTIFICATE

We pay benefits in accordance with all the terms and conditions of the Group Policy for Medical Service charges that are described in the section called "Medical Services" and incurred by a Covered Person as the result of the Medically Necessary treatment of:

INJURY that occurs after his/her Certificate Date; or

SICKNESS that begins after his/her Certificate Date.

This Certificate is not the contract of insurance, however it provides evidence of coverage under the Group Policy. **READ IT CAREFULLY.**

IMPORTANT NOTICE CONCERNING STATEMENTS IN YOUR ENROLLMENT APPLICATION - You should read Your Enrollment Application and all documents attached to this Certificate. **Omissions or misstatements in Your Enrollment Application or any attached documents may cause Us to deny an otherwise valid claim or rescind coverage.** Carefully check all documents. You must advise Our Underwriting Department in writing within 10 days of Your receipt of this Certificate if You determine that any information or medical history is incomplete, incorrect, or has changed since the date of Your Enrollment Application.

Your Enrollment Application and all attached documents are part of the Group Policy. We provide coverage described in the Group Policy on the basis that all of the answers to the questions and all the material information contained in the documents are correct and complete. No agent or employee, except an officer of the Company, has the authority to waive any of the requirements in the documents or waive any of the provisions of the Group Policy.

We do not provide coverage until we have approved Your Enrollment Application and Your Initial Premium has been paid. The Initial Premium pays for the Initial Term of coverage. The Initial Term of coverage begins at 12:01 A.M., local time, at Your residence on Your Certificate Date. Coverage is continued in accordance with all of the provisions of the Group Policy.

10 DAY RIGHT TO EXAMINE THIS CERTIFICATE – You may return this Certificate to Us for any reason within 10 days after You receive it. You may bring it in person or mail it to Us. At the time You return this Certificate, coverage under the Group Policy is void from the beginning. We will refund any premium paid.

PREMIUMS ARE SUBJECT TO CHANGE - Please refer to the section titled **PREMIUMS**.

THE GROUP POLICY – You may review the Group Policy during usual business hours at the Group Policyholder's office.

SECRETARY

PRESIDENT

THE GROUP POLICY PROVIDES COVERAGE FOR HOSPITAL EXPENSES DESCRIBED IN THE GROUP POLICY AND THIS CERTIFICATE. WHEN SELECTED, A PREFERRED PROVIDER COMPONENT IS INCLUDED WITH THIS COVERAGE.

CERTIFICATE SCHEDULE

REMARKS - SEE ANY ATTACHED FORMS

NOTICE –

BENEFIT OPTION – A
COVERAGE – INDIVIDUAL/ FAMILY
DEDUCTIBLE AMOUNT – ($750, $1,500, $2,000, $2,500, $5,000, $10,000, $15,000, $20,000, $25,000) PER COVERED PERSON PER CALENDAR YEAR
RATE OF PAYMENT – (100%, 80%, 50%)
STOP-LOSS AMOUNT - ($5,000, $10,000)
MAXIMUM POLICY BENEFIT FOR EACH INJURY OR SICKNESS PER COVERED PERSON -- $1,000,000 ($2,000,000)

REFER TO MEDICAL SERVICES FOR A DESCRIPTION OF EXPENSES COVERED BY THE POLICY.
REFER TO EXCEPTIONS FOR A DESCRIPTION OF EXPENSES THAT ARE NOT COVERED BY THE POLICY.

CERTIFICATE NUMBER:
CERTIFICATE DATE:

COVERED PERSONS:	**RELATIONSHIP**	**AGE**	**DATE OF BIRTH**

GROUP POLICY NUMBER:
GROUP POLICY DATE:
GROUP POLICYHOLDER:
STATE OF ISSUE:

CERTIFICATE SCHEDULE

REMARKS - SEE ANY ATTACHED FORMS

NOTICE –

BENEFIT OPTION – A
COVERAGE – INDIVIDUAL/ FAMILY
DEDUCTIBLE AMOUNT – ($750, $1,500, $2,000, $2,500, $5,000, $10,000, $15,000, $20,000, $25,000) PER COVERED PERSON PER CALENDAR YEAR
RATE OF PAYMENT –
IN-NETWORK - (100%, 80%, 50%)
OUT-OF-NETWORK - (80% OF THE FIRST $5,000, 100% THEREAFTER)

(60% UP TO THE STOP LOSS AMOUNT, 100% THEREAFTER)

(30% UP TO THE STOP LOSS AMOUNT, 100% THEREAFTER)

STOP-LOSS AMOUNT - ($5,000, $10,000)
MAXIMUM POLICY BENEFIT FOR EACH INJURY OR SICKNESS PER COVERED PERSON -- $1,000,000 ($2,000,000)

REFER TO MEDICAL SERVICES FOR A DESCRIPTION OF EXPENSES COVERED BY THE POLICY.
REFER TO EXCEPTIONS FOR A DESCRIPTION OF EXPENSES THAT ARE NOT COVERED BY THE POLICY.

CERTIFICATE NUMBER:
CERTIFICATE DATE:

COVERED PERSONS:	**RELATIONSHIP**	**AGE**	**DATE OF BIRTH**

GROUP POLICY NUMBER:
GROUP POLICY DATE:
GROUP POLICYHOLDER:
STATE OF ISSUE:

CERTIFICATE SCHEDULE

REMARKS - SEE ANY ATTACHED FORMS

NOTICE –

BENEFIT OPTION – B

RATE OF PAYMENT – (100%)
DEDUCTIBLE AMOUNT – ($3,000, $4,000, $5,000, $10,000)
UNPAID MEDICAL SERVICE
CHARGE MAXIMUM - ($3,000, $4,000, $5,000, $10,000) INCLUDES DEDUCTIBLE

RATE OF PAYMENT – (80%)
DEDUCTIBLE AMOUNT – ($3,000, $4,000, $5,000, $10,000)
UNPAID MEDICAL SERVICE
CHARGE MAXIMUM - ($7,000, $8,000, $9,000, $14,000) INCLUDES DEDUCTIBLE

RATE OF PAYMENT – (50%)
DEDUCTIBLE AMOUNT – ($3,000, $4,000, $5,000, $10,000)
UNPAID MEDICAL SERVICE
CHARGE MAXIMUM - ($8,000, $9,000, $10,000, $15, 000) INCLUDES DEDUCTIBLE

MAXIMUM POLICY BENEFIT FOR EACH
INJURY OR SICKNESS PER COVERED PERSON -- $1,000,000 ($2,000,000)

REFER TO MEDICAL SERVICES FOR A DESCRIPTION OF EXPENSES COVERED BY THE POLICY.
REFER TO EXCEPTIONS FOR A DESCRIPTION OF EXPENSES THAT ARE NOT COVERED BY THE POLICY.

CERTIFICATE NUMBER:
CERTIFICATE DATE:

COVERED PERSONS:	**RELATIONSHIP**	**AGE**	**DATE OF BIRTH**

GROUP POLICY NUMBER:
GROUP POLICY DATE:
GROUP POLICYHOLDER:
STATE OF ISSUE:

CERTIFICATE SCHEDULE

REMARKS - SEE ANY ATTACHED FORMS

NOTICE –

BENEFIT OPTION – B

RATE OF PAYMENT –
IN-NETWORK - (100%)
OUT-OF-NETWORK - (80%)
DEDUCTIBLE AMOUNT – ($3,000, $4,000, $5,000, $10,000)
UNPAID MEDICAL SERVICE
CHARGE MAXIMUM - ($3,000, $4,000, $5,000, $10,000) INCLUDES DEDUCTIBLE

RATE OF PAYMENT –
IN-NETWORK – (80%)
OUT-OF-NETWORK - (60%)
DEDUCTIBLE AMOUNT – ($3,000, $4,000, $5,000, $10,000)
UNPAID MEDICAL SERVICE
CHARGE MAXIMUM - ($7,000, $8,000, $9,000, $14,000) INCLUDES DEDUCTIBLE

RATE OF PAYMENT –
IN-NETWORK - (50%)
OUT-OF-NETWORK - (30%)
DEDUCTIBLE AMOUNT – ($3,000, $4,000, $5,000, $10,000)
UNPAID MEDICAL SERVICE
CHARGE MAXIMUM - ($8,000, $9,000, $10,000, $15, 000) INCLUDES DEDUCTIBLE

MAXIMUM POLICY BENEFIT FOR EACH
INJURY OR SICKNESS PER COVERED PERSON -- $1,000,000 ($2,000,000)

REFER TO MEDICAL SERVICES FOR A DESCRIPTION OF EXPENSES COVERED BY THE POLICY.
REFER TO EXCEPTIONS FOR A DESCRIPTION OF EXPENSES THAT ARE NOT COVERED BY THE POLICY.

CERTIFICATE NUMBER:
CERTIFICATE DATE:
COVERED PERSONS: RELATIONSHIP AGE DATE OF BIRTH

GROUP POLICY NUMBER:
GROUP POLICY DATE:
GROUP POLICYHOLDER:
STATE OF ISSUE:

CERTIFICATE SCHEDULE

REMARKS - SEE ANY ATTACHED FORMS

THE PLAN DEDUCTIBLE AND UNPAID MEDICAL SERVICES MAXIMUM WILL CHANGE IN ACCORDANCE WITH FEDERAL REQUIREMENTS.

NOTICE –

COVERAGE – (INDIVIDUAL/ FAMILY**)**
BENEFIT OPTION – NOT APPLICABLE
RATE OF PAYMENT – (100%)
DEDUCTIBLE AMOUNT –
INDIVIDUAL - ($1,500, $2,000, $2,500, $5,000)
FAMILY - ($3,000, $4,000, $5,000, $10,000)
UNPAID MEDICAL SERVICE CHARGE MAXIMUM - **INDIVIDUAL** - ($1,500, $2,000, $2,500, $5,000) INCLUDES DEDUCTIBLE
FAMILY - ($3,000, $4,000, $5,000, $10,000) INCLUDES DEDUCTIBLE

RATE OF PAYMENT – (80%)
DEDUCTIBLE AMOUNT –
INDIVIDUAL - ($1,500, $2,000, $2,500)
FAMILY - ($3,000, $4,000, $5,000)
UNPAID MEDICAL SERVICE CHARGE MAXIMUM - **INDIVIDUAL** - ($3,500, $4,000, $4,500) INCLUDES DEDUCTIBLE
FAMILY - ($7,000, $8,000, $9,000) INCLUDES DEDUCTIBLE

RATE OF PAYMENT – (50%)
DEDUCTIBLE AMOUNT –
INDIVIDUAL - ($1,500, $2,000, $2,500)
FAMILY - ($3,000, $4,000, $5,000)
UNPAID MEDICAL SERVICE CHARGE MAXIMUM - **INDIVIDUAL** - ($4,000, $4,500, $5,000) INCLUDES DEDUCTIBLE
FAMILY - ($8,000, $9,000, $10,000) INCLUDES DEDUCTIBLE

MAXIMUM POLICY BENEFIT FOR EACH INJURY OR SICKNESS PER COVERED PERSON -- $1,000,000 ($2,000,000)

REFER TO MEDICAL SERVICES FOR A DESCRIPTION OF EXPENSES COVERED BY THE POLICY.
REFER TO EXCEPTIONS FOR A DESCRIPTION OF EXPENSES THAT ARE NOT COVERED BY THE POLICY.

CERTIFICATE NUMBER:
CERTIFICATE DATE:

COVERED PERSONS:	**RELATIONSHIP**	**AGE**	**DATE OF BIRTH**

GROUP POLICY NUMBER:
GROUP POLICY DATE:
GROUP POLICYHOLDER:
STATE OF ISSUE:

CERTIFICATE SCHEDULE

REMARKS - SEE ANY ATTACHED FORMS
THE PLAN DEDUCTIBLE AND UNPAID MEDICAL SERVICES MAXIMUM WILL CHANGE IN ACCORDANCE WITH FEDERAL REQUIREMENTS.

NOTICE –OUT-OF-NETWORK PENALTY – COVERAGE UNDER THE GROUP POLICY INCLUDES A PPO COMPONENT. THE CERTIFICATEHOLDER IS ENCOURAGED TO USE AN IN-NETWORK PROVIDER TO RECEIVE THE MAXIMUM AMOUNT PAYABLE FOR ELIGIBLE MEDICAL SERVICE CHARGES. USE OF AN OUT-OFNETWORK PROVIDER RESULTS IN A 20% REDUCTION OF ANY OTHERWISE ELIGIBLE MEDICAL SERVICE CHARGE THAT WE DO NOT PAY DUE TO A COVERED PERSON'S VOLUNTARY USE OF AN OUT-OF-NETWORK PROVIDER.

COVERAGE – (INDIVIDUAL/ FAMILY**)**
BENEFIT OPTION – NOT APPLICABLE
RATE OF PAYMENT – (100%)
DEDUCTIBLE AMOUNT –
INDIVIDUAL - ($1,500, $2,000, $2,500, $5,000)
FAMILY - ($3,000, $4,000, $5,000, $10,000)
UNPAID MEDICAL SERVICE
CHARGE MAXIMUM - INDIVIDUAL - ($1,500, $2,000, $2,500, $5,000) INCLUDES DEDUCTIBLE
FAMILY - ($3,000, $4,000, $5,000, $10,000) INCLUDES DEDUCTIBLE

RATE OF PAYMENT – (80%)
DEDUCTIBLE AMOUNT –
INDIVIDUAL - ($1,500, $2,000, $2,500)
FAMILY - ($3,000, $4,000, $5,000)
UNPAID MEDICAL SERVICE
CHARGE MAXIMUM - INDIVIDUAL - ($3,500, $4,000, $4,500) INCLUDES DEDUCTIBLE
FAMILY - ($7,000, $8,000, $9,000) INCLUDES DEDUCTIBLE

RATE OF PAYMENT – (50%)
DEDUCTIBLE AMOUNT –
INDIVIDUAL - ($1,500, $2,000, $2,500)
FAMILY - ($3,000, $4,000, $5,000)
UNPAID MEDICAL SERVICE
CHARGE MAXIMUM - INDIVIDUAL - ($4,000, $4,500, $5,000) INCLUDES DEDUCTIBLE
FAMILY - ($8,000, $9,000, $10,000) INCLUDES DEDUCTIBLE

MAXIMUM POLICY BENEFIT FOR EACH
INJURY OR SICKNESS PER COVERED PERSON -- $1,000,000 ($2,000,000)

REFER TO MEDICAL SERVICES FOR A DESCRIPTION OF EXPENSES COVERED BY THE POLICY.
REFER TO EXCEPTIONS FOR A DESCRIPTION OF EXPENSES THAT ARE NOT COVERED BY THE POLICY.

CERTIFICATE NUMBER:
CERTIFICATE DATE:
COVERED PERSONS: RELATIONSHIP AGE DATE OF BIRTH

GROUP POLICY NUMBER:
GROUP POLICY DATE:
GROUP POLICYHOLDER:
STATE OF ISSUE:

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PREMIUMS

Premiums are due on the first day of each term that follows the Initial Term. This is called the Premium Due Date. The required premium will depend on Your premium class. We determine the premium class on each Premium Due Date. We will NOT CHANGE Your premium prior to the first anniversary of Your Certificate Date, unless:

1. Coverage changes; or
2. Residence changes.

After the first anniversary of Your coverage, We will change premiums:

1. Annually, based on attained age;
2. When You move to a different rating zone; or
3. Anytime, and from time to time, that We decide to change rates for persons in Your or a Covered Person's class.

Changes will apply to premiums due on or after the effective date of the change. The new rates will apply on a class basis as determined by Us. We will give You 30 days notice before any premium change.

WAIVER OF PREMIUM - If You die, We will waive premiums for remaining Covered Persons for 12 months beginning with the next Premium Due Date following Our receipt of due proof of Your death. During this premium waiver period no increases in benefits or addition of Covered Persons, except newborns, will be considered. All provisions for Loss of Eligibility for Covered Persons will remain applicable during this premium waiver period.
At the end of the 12 months during which premiums were waived, coverage may be continued for Covered Persons by resuming payment of the required premium.

DEFINITIONS

AMBULANCE means a motor vehicle, helicopter, or fixed wing aircraft specially equipped to transport Sick and Injured people. A common carrier is not an Ambulance.

CALENDAR YEAR means the twelve-month period that begins January 1 and ends December 31, each year.

CERTIFICATE means the written description of coverage provided to You as evidence of coverage under the Group Policy.

CERTIFICATE DATE means the date, shown in the Certificate Schedule, when coverage begins for the Covered Persons originally covered under the Group Policy. We use the Certificate Date to determine the anniversary dates of coverage under the Group Policy. It also refers, separately, to the date We add a Covered Person to the Group Policy or when any change in coverage occurs.

CERTIFICATEHOLDER means the Applicant named in the Enrollment Application or any successor thereof named to assume ownership privileges under this Policy. Such person, regardless of title, has exclusive ownership privileges under this Policy. These privileges include, but are not limited to, his/her right to change coverage under this Policy for themselves or any Covered Person.

CLOSE RELATIVE means You or anyone related to You by blood, marriage, or adoption; or a court appointed representative.

COMPLICATIONS OF PREGNANCY means:

1. conditions, requiring Hospital confinement (when the pregnancy is not terminated), whose diagnosis are distinct from pregnancy, but are adversely affected by pregnancy or are caused by pregnancy, such as (1) acute nephritis; (2) nephrosis; (3) cardiac decompensation;(4) HELLP syndrome; (5) uterine rupture; (6) amniotic fluid embolism; (7) chorioamnionitis; (8) fatty liver in pregnancy; (9) septic abortion; (10) placenta accreta; (11) gestational hypertension; (12) puerperal sepsis; (13) peripartum cardiomyopathy; (14) cholestasis in pregnancy; (15) thrombocytopenia in pregnancy; (16) placenta previa; (17) placental abruption; (18) acute cholecystitis and pancreatitis in pregnancy; (19) postpartum hemmorrhage; (20) septic pelvic thromboplebitis; (21) retained placenta; (22) venous air embolus associated with pregnancy; (23) miscarriage; or (24) an emergency c-section required because of (a) fetal or maternal distress during labor, or (b) severe pre-eclampsia, or (c) arrest of descent or dilitation, or (d) obstruction of the birth canal by fibroids or ovarian tumors, or (e) necessary because of the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that, in the absence of immediate medical attention, will result in placing the life of the mother or fetus in jeopardy. A c-section delivery is not considered to be an emergency c-section if it is merely for the convenience of the patient and/or doctor or solely due to a previous c-section; and

2. Treatment, diagnosis or care for conditions, including the following, when the condition was caused by, necessary because of, or aggravated by the pregnancy: (1) hyperthyroidism, (2) hepatitis B 0r C, (3) HIV (4) Human papilloma virus, (5) abnormal PAP, (6) syphilis, (7) chlamydia, (8) herpes, (9) urinary tract infections, (10) thromboembolism, (11) appendicitis, (12) hypothyroidism, (13) pulmonary embolism, (14) sickle cell disease, (15) tuberculosis, (16) migraine headaches, (17) depression, (18) acute myocarditis, (19) asthma, (20) maternal cytomegalovirus, (21) urolithiasis, (22) DVT prophylaxis, (23) ovarian dermoid tumors, (24) biliary atresia and/or cirrhosis, (25) first trimester adnexal mass, (25) hyditidiform mole or (26) ectopic pregnancy.

COVERED PERSON means each person named as a Covered Person on the Certificate Schedule whose coverage under the Group Policy has not terminated.

DOCTOR means a person, other than You or a Close Relative, who is duly licensed to provide the type of medical treatment for which benefits are provided under the Group Policy, and acting within the scope of that license.

EMERGENCY means a medical condition of recent onset and sufficient severity to cause a prudent person to believe that without immediate medical attention the condition may result in:

1. Placing the patient's health in serious jeopardy;
2. Serious impairment to bodily functions;
3. Serious dysfunction of any bodily organ or part;
4. Serious disfigurement; or
5. In the case of a pregnant woman, serious jeopardy to the health of the fetus.

EXPERIMENTAL OR INVESTIGATIONAL MEDICINE means any of the following (generally, individually or collectively, called Regimen) that, when used to treat a Covered Person's specific Injury or Sickness, are experimental, investigational or oriented toward research:

1. Equipment;
2. Drugs or dosages;
3. Devices, services, supplies, tests or medical treatment or procedures; or
4. All related treatment and procedures.

We consider a Regimen as **EXPERIMENTAL OR INVESTIGATIONAL MEDICINE** if:

1. The U.S. Food and Drug Administration (FDA) has not given final approval to the Regimen for the lawful marketing for the treatment of the specific Injury or Sickness; or
2. The American Medical Association (AMA) has not approved or endorsed the Regimen for the treatment of the specific Injury or Sickness; or
3. The National Institutes of Health (NIH) or its affiliated institutes have not approved or endorsed the Regimen for the treatment of the specific Injury or Sickness; or
4. The Regimen is:

    a) Currently used or will be used or studied in proposed or ongoing clinical research or clinical trials as evidenced by the Informed Consent or investigational protocol; or
    b) Part of a proposed or ongoing phase I, II or III clinical trial; or
    c) Subject of proposed or ongoing research or studies to determine its dosage, safety, toxicity, efficacy, or its efficacy as compared to other means of treatment or diagnosis; or

5. The opinion of medical or scientific experts indicates that further studies, research or clinical trials are necessary to determine the Regimen's dosage, safety, toxicity, efficacy or its efficacy as compared to other means of treatment or diagnosis. The opinion of medical or scientific experts is as reflected in:

    a) Published reports or articles in medical or scientific literature; or
    b) Written protocol(s) used by the treating facility or other facilities studying the same or substantially similar Drugs, devices, services, supplies, tests, treatments, or procedures; or
    c) The Informed Consent used by the treating facility or other facilities studying the same or substantially similar Drugs, devices, services, supplies, tests, treatments, or procedures.

We will not exclude a drug for the treatment of cancer because the FDA has not approved the drug for the treatment of the specific type of cancer for which a Doctor has prescribed the drug. However, standard reference compendia or medical literature must recognize the drug for treatment of that specific type of cancer. We will not cover a drug:

1. That the FDA has not approved; or
2. The FDA has contraindicated its use.

HOME HEALTH CARE PLAN means that a licensed Home Health Care Agency provides care and treatment for an Injury or Sickness at a Covered Person's residence. A Doctor must set up and approve a plan in writing.

HOSPICE means an alternative way of caring for terminally ill individuals provided by an entity licensed to provide hospice care for terminally ill individuals and his/her Immediate Families.

HOSPITAL means a facility that:
1. Is licensed as a Hospital in the jurisdiction where it operates; and
2. Provides medical and surgical services for the treatment of Injury or Sickness under the supervision of a Doctor.

The term "Hospital" does not include:

1. A convalescent, nursing, rest or rehabilitative facility; a home for the aged; a special ward, floor or other accommodation for convalescent, skilled nursing, rehabilitation, ambulatory or extended care purposes, including the separate section of a building that houses an acute care facility; hotel units, residential annexes, nurse administered units in or associated with a Hospital; or a psychiatric/substance abuse facility.

2. Any military or veteran's Hospital, soldier's home or any Hospital contracted for or operated by the Federal Government or any agencies thereof for the treatment of members or former members of the Armed Forces, unless the Covered Person is legally required to pay for services in the absence of coverage under the Group Policy.

HOSPITAL CONFINED means that a Covered Person is admitted to a Hospital as an overnight resident bed patient. "Hospital Confined" does not include a Covered Person's treatment in a Same Day Surgery facility, Emergency room, or an observation room.

INJURY (Injured) means accidental bodily injury sustained by the Covered Person, which is the direct cause of loss, independent of disease, bodily infirmity, or any other cause which occurs while coverage under the Group Policy is in force.

INTENSIVE CARE UNIT, CORONARY CARE UNIT OR NEONATAL INTENSIVE CARE UNIT means that part of a Hospital specifically designed as an intensive care unit that is permanently equipped and staffed to provide more extensive care for critically ill or Injured patients than is available in other Hospital rooms or wards. Services provided include close observation by trained and qualified personnel whose duties are primarily confined to the part of the Hospital for which an additional charge is made.

LIMITING AGE for Your children is attained age 26. This is Your coverage anniversary next following the child's 26th birthday.

MEDICALLY NECESSARY means a service or supply necessary and appropriate for the diagnosis or treatment of an Injury or Sickness based upon current generally accepted medical practices. The fact that a Doctor may prescribe, order, recommend, or approve a service or supply does not, of itself, make the service or supply Medically Necessary. A service or supply is not Medically Necessary if:

1. It is provided only as a convenience to the Covered Person or provider;
2. It is not appropriate treatment for the Covered Person's diagnosis or symptoms;
3. It exceeds (in scope, duration, or intensity) that level of care that is needed to provide safe, adequate, and appropriate diagnosis or treatment; or
4. It is Experimental or Investigational Medicine.

MEDICARE means a United States government program set up to provide health care benefits. Medicare includes:

1. The program under Title XVIII of Social Security with any later changes; or
2. Similar programs meant to pay for health care.

MEDICINES OR DRUGS means any medication or medicinal substance that the U.S. Food and Drug Administration has approved for use. The Medicines or Drugs must be used in the Hospital.

MENTAL DISORDER means a disease or disorder, regardless of its cause, that affects the mind or behavior. Categories of mental disorders include mood disorders, anxiety disorders, psychotic disorders, eating disorders, developmental disorders, personality disorders, and other generally accepted disorders of a similar type.

NURSE means any of these:

1. Licensed Registered Nurse (R.N.);
2. Licensed Practical Nurse (L.P.N.);
3. Licensed Vocational Nurse (L.V.N.); or
4. Nurse Practitioner.

"Nurse" does not include a Covered Person or any Close Relative.

ORGAN TRANSPLANT means the placement of tissue or an organ from a live or cadaver donor in a Covered Person. This includes tissue, organ, or cells harvested and returned to the same person, where such tissue or organ is somewhat independent from all other parts of the human body and performs a special or unique function. The source of the tissue, organ, or cells may be from another person. An Organ Transplant does not include the placement of a mechanical or man-made device or substance when the device or substance:

1. Is intended to serve as a substitute for the tissue or organ; or
2. Aids in the performance of the tissue or organ.

An Organ Transplant does not include the grafting of solid tissue or organ such as bone or skin.

PREEXISTING CONDITION means a disease or physical condition of a Covered Person, not otherwise excluded by name or specific description on the date of the Person's loss, which existed prior to the Covered Person's effective date under the Group Policy. Any exclusion or limitation applies only to a disease or physical condition for which medical advice or treatment was received by the Covered Person during the 12 months prior to the effective date of coverage under the Group Policy. In no event will the exclusion or limitation apply to loss incurred after the earlier of:

1. The end of a continuous period of 12 months commencing on or after the effective date of the Covered Person's coverage during all of which the Person received no advice or treatment in connection with such disease or physical condition; or
2. The end of the 2-year period commencing on the effective date of the Covered Person's effective date of coverage under the Group Policy.

REASONABLE AND CUSTOMARY CHARGES means the dollar amount charged that is the lesser of:

1. The actual dollar amount charged;
2. The dollar amount usually charged for the service by the provider who furnishes it; or
3. The prevailing dollar amount charge made for a service in a geographical area made by a facility or person.

SAME DAY SURGERY FACILITY means a licensed medical facility or a part of a Hospital:

1. With an organized staff of Doctors;
2. That is permanently equipped and operated primarily for the purpose of performing surgical procedures;
3. That does not provide accommodations for overnight stays; and
4. That provides continuous Doctor services and nursing services whenever a patient is in the facility.

The term "Same Day Surgery Facility" does not include a:

1. Hospital Emergency room;
2. Trauma center; or
3. Doctor's office or Clinic.

SICKNESS means a Covered Person's illness, disease, or condition that begins after the Certificate Date and while the Covered Person has coverage under the Group Policy. Sickness also includes an illness, disease or condition that begins before the Certificate Date if it is shown on the Enrollment Application and We have not excluded it from coverage by name or specific description. Sickness includes any complications or recurrences that relate to such Sickness while the Group Policy's coverage is in effect for the Covered Person.

US, WE, OUR or THE COMPANY means American National Life Insurance Company of Texas (ANTEX).

YOU or YOUR means the Certificateholder.

BENEFITS

WHAT WE PAY – Benefits are payable under the Group Policy in accordance with Benefit Option A or Benefit Option B, each described below. Each Certificateholder's selected Benefit Option is shown in Your Certificate Schedule. The Benefit Option in effect on January 1st of each year will remain in effect for the remainder of the same Calendar Year. Benefits will not be paid under more than one benefit option during a Calendar Year. All benefits payable under the Group Policy are subject to the Group Policy's Maximum Policy Benefit for each Injury or Sickness per Covered Person. A Covered Person's selected Deductible Amount, Rate of Payment, and Stop Loss Amount are each shown in his/her Certificate Schedule.

BENEFIT OPTION A - Benefits are payable under the Group Policy after a Covered Person incurs charges during a Calendar Year for Medical Services in excess of his/her Deductible Amount. Benefits will be paid at the Rate of Payment. If Your selected Rate of Payment is less than 100%, once charges for Medical Services exceed the Stop-Loss Amount shown in the Certificate Schedule during a Calendar Year, the Rate of Payment for the remainder of the Calendar Year is 100%.

BENEFIT OPTION B - Benefits are payable under the Group Policy after combined charges for Medical Services incurred by one or more Covered Persons during a Calendar Year exceed the Deductible Amount. Benefits will be paid at the Rate of Payment. If Your selected Rate of Payment is less than 100%, once combined unpaid charges for Medical Services incurred by one or more Covered Persons during a Calendar Year exceed the Unpaid Medical Service Charge Maximum shown in Your Certificate Schedule, the Rate of Payment for the remainder of the Calendar Year is 100%. In the event coverage under this Benefit Option B is provided for only one Covered Person, the Deductible Amount shown in Your Certificate Schedule will be reduced by 50%.

UNPAID MEDICAL SERVICES MAXIMUM – This is the maximum amount that You pay each Calendar Year comprised of charges for Medical Services applied to the Deductible Amount and Rate of Payment for Medical Services before We pay 100% of Medical Services charges. There is an Individual or a Family Unpaid Medical Services Maximum depending on whether family coverage is provided. Once Covered Persons have met the Family Unpaid Medical Services Maximum, individually or collectively, We will pay 100% of charges for Medical Services for all Covered Persons for the remainder of the Calendar Year. The Policy Schedule shows Unpaid Medical Services Maximum. **We <u>do not</u> apply the following toward the Unpaid Medical Services Maximum: any non-Medical Service charge, or ineligible expense.**

POLICY MAXIMUM FOR EACH INJURY OR SICKNESS is shown in each Certificateholder's Certificate Schedule. This Maximum applies to each Covered Person.

THE FOLLOWING PROVISIONS DO <u>NOT</u> APPLY IF BENEFIT OPTION B IS IN EFFECT.

FAMILY DEDUCTIBLE MAXIMUM – Once three family members have met their respective Deductible Amounts in a Calendar Year, no further Deductible Amount will be required for the remainder of the Calendar Year.

COMMON ACCIDENT DEDUCTIBLE – If two or more Covered Persons incur Medical Service charges from Injuries sustained in a single accident, We will apply the lesser of:

1. The Deductible Amount;
2. The remainder of each Covered Person's respective Deductible Amount; or
3. The remainder of the Family Deductible Maximum.

VANISHING DEDUCTIBLE AMOUNT – This provision does not apply to a Deductible Amount in excess of $15,000. If coverage under the Group Policy is in effect for a complete Calendar Year and We do not pay any benefits on behalf of any Covered Person, We will reduce the Cash Deductible Amount for the following Calendar Year by 25%. However, We will give no further reductions after the Cash Deductible Amount is reduced to zero. If We pay benefits on behalf of any Covered Person during a Calendar Year, the Cash Deductible Amount for all Covered Persons for the next Calendar Year is the amount shown on the Certificate Schedule. We will extend this provision to any Covered Person added during a Calendar Year during which the Cash Deductible Amount has been reduced.

MEDICAL SERVICES

WE PAY BENEFITS FOR REASONABLE AND CUSTOMARY CHARGES INCURRED FOR THE FOLLOWING MEDICAL SERVICES AT THE APPLICABLE RATE OF PAYMENT. Benefits payable for Medical Services are subject to all terms, limits, and conditions of the Group Policy.

An expense is "incurred" on the date a provider renders the service or furnishes the supplies.

The following are Medical Services under the Group Policy :

Professional Ambulance Service (air or ground) – Reasonable and Customary Charges for transportation to the nearest Hospital qualified to provide for the Covered Person's Medically Necessary Emergency treatment.

Hospital Stay - The Hospital charge for each day a Covered Person is Hospital Confined. Such charge will include those for:

1. Semi-private room confinement, excluding any separate charges such as room, nursing services, maintenance, utilities, and similar items;
2. Intensive Care Unit, Burn Unit, Coronary Care Unit, and Neonatal Intensive Care Unit confinement, up to three times the Hospital's average semi-private room rate; and
3. Medically Necessary miscellaneous services and supplies used for the treatment of the Hospital Confined Covered Person.

Services **DO NOT** include: charges for take-home medicines or drugs, personal or convenience items, or items that are not intended primarily for use while Hospital Confined.

Doctor Visits - Reasonable and Customary Charges for the Covered Person's Doctors' (other than the surgeon) visits when Hospital Confined. For purposes of this provision, a Doctor's consultation is a visit.

Surgery - Reasonable and Customary Charges made by an operating surgeon. If two or more surgeries are performed through the same incision, We will pay the one providing the greatest benefit under the Group Policy. We will also pay [50%] of the benefits otherwise payable for the other surgeries performed through separate incisions during the same operative session. Charges must be incurred while a Covered Person is Hospital Confined or in a Same Day Surgery Facility.

Same Day Surgery Facility - Reasonable and Customary Charges for services provided for a Covered Person by a Same Day Surgery Facility on the day surgery is performed.

If a Covered Person is retained in the Same Day Surgery Facility for more than 18 hours, charges for use of such facility will be limited to the average semi-private room rate consistent with Reasonable and Customary Charges for Hospitals in the area where the Same Day Surgery Facility is located.

Assistant Surgeon - Actual charges for services provided during a surgical procedure by an Assistant Surgeon, up to 25% of the Reasonable and Customary Charge of the primary surgeon. Charges must be incurred while a Covered Person is Hospital Confined or in a Same Day Surgery Facility.

Second Surgical Opinion - Reasonable and Customary Charges for a Doctor providing a second surgical opinion regarding the recommendation for surgery. If the initial and second surgical opinions conflict, We will pay benefits for a third surgical opinion. The Deductible Amount does not apply to a second or third opinion.

Anesthesia Administration - Reasonable and Customary Charges for the administration of anesthesia by an anesthesiologist to a Covered Person undergoing surgery while Hospital Confined or in a Same Day Surgery Facility. The anesthesiologist must be at the operation solely to provide the anesthesia service.

We will reduce benefits otherwise payable had an anesthesiologist administered anesthesia by [50%] if a nurse anesthetist, operating Doctor, or assistant Surgeon administers the anesthesia, including any incidental fluids, as part of a covered surgical procedure. When both an anesthesiologist and a nurse anesthetist bill for the same operative session, benefits will be limited to the Reasonable and Customary charges otherwise payable had the anesthesiologist been the sole provider of such services.

Coverage includes charges incurred for those for services performed in connection with dental procedures in a Hospital or Ambulatory Surgical Center when the Doctor treating the Covered Person certifies that, because of the patient's age or condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the procedures and the Covered Person is: (1) a child under 7 years of age who is determined by two dentists licensed in Arkansas to require, without delay, necessary dental treatment in a Hospital or Ambulatory Surgical Center for a significantly complex dental condition; (2) a person with a diagnosed serious mental of physical condition; or (3) a person with a significant behavioral problem as determined by the Covered Person's Doctor. This benefit does not apply to services performed in connection with temporomandibular joint disorders.

Breast Reconstruction - Reasonable and Customary Charges for the following services and supplies incident to mastectomy:

1. Reconstruction of the affected breast;
2. Reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and physical complications of all stages of mastectomy, including lymphedemas.

Benefits under this coverage will be subject to all the terms and conditions of the Group Policy, except any Exception relating to cosmetic surgery.

Pathology - Reasonable and Customary Charges for pathology services while the Covered Person is Hospital Confined or in a Same Day Surgery Facility. Professional services relating to automated pathology tests are <u>not</u> covered.

Radiology - Reasonable and Customary Charges for radiology services provided for a Covered Person while Hospital Confined or in a Same Day Surgery Facility.

Chemotherapy – Reasonable and Customary Charges for chemotherapy.

Physiotherapy - Reasonable and Customary Charges for physical, speech, occupational, or inhalation therapy. Such therapy must be provided by a Hospital based therapy facility and must result from a Covered Person's treatment in a Hospital or Same Day Surgery Facility.

Radiation Therapy – Reasonable and Customary Charges for radiation therapy.

Home Health Care - Reasonable and Customary Charges for Home Health Care, up to [$7,500] per Calendar Year when a Covered Person receives Home Health Care. The Home Health Care must:

1. Begin within 7 days of a prior Hospital Stay of at least 3 days;
2. Be provided in lieu of a Hospital Stay;
3. Be for services related to the treatment of the same Sickness or Injury for which the Covered Person was Hospital Confined; and
4. Be administered under a Home Health Care Plan.

Hospice Care Benefit - Reasonable and Customary Charges for Hospice Care provided by a licensed Hospice agency. We will not pay benefits under this provision and under another benefit provision of the Group Policy. We only pay benefits for Hospice Care when the Covered Person's Doctor certifies that the Covered Person's life expectancy is less than six months.

Mammogram - Reasonable and Customary Charges in excess of a Covered Person's payment of [$25] for one mammogram per Calendar Year. We pay the benefit whether or not the Covered Person is Hospital Confined. We do not apply such payment to the Deductible Amount or the Rate of Payment.

Foreign Emergency Treatment
We will pay for benefits for Medical Services resulting from charges for Emergency treatment that a Covered Person receives in a foreign country. Benefits payable will be the lesser of: (1) the actual charges for the services; or (2) the benefit for Medical Services that We would have paid if the Covered Person had received the Emergency treatment in the location where the Covered Person resides.

Complications of Pregnancy

If a Covered Person has Complications of Pregnancy while covered under the Group Policy, Medical Services incurred for treatment of such Complications of Pregnancy will be considered for payment as if they had resulted from Sickness. If an expense does not result solely from the treatment of the Complications of Pregnancy, then it will be deemed due to normal pregnancy and not covered under the Group Policy.

Organ Transplant Donor Charges - We will pay donor benefits for covered Organ Transplants:

1. Up to [$15,000] in Medical Services; if
2. You or a Covered Person are legally responsible for the charges.

ARKANSAS RESIDENT BENEFITS – The following benefits apply only when described services are provided to a Covered Person who is an Arkansas resident. Except as otherwise stated, they are subject to all the terms and conditions of the Group Policy.

Newborn Infants – When the Certificate evidences coverage for persons in addition to You, and You have given Us notice of a newborn as required by Automatic Coverage of Newborn and Adopted Children, coverage will include the Reasonable and Customary Charges incurred for the Medically Necessary care and treatment of a newborn child, while the child is Hospital Confined, as follows: (a) coverage for Sickness or Injury, congenital defects, and premature birth; (b) coverage for tests for hypthyroidism, phenylketonuria, galactosemia, sickle-cell amenia, and all other disorders of metabolism for which screening is performed by or for the State of Arkansas, as well as any testing of newborn infants hereafter mandated by law; and (c) a minimum of 48 hours up to 5 full days of routine nursery care and pediatric charges for a well newborn in a Hospital nursery or until the mother is discharged from the Hospital following the birth of the child, whichever is the lesser period of time.

Speech and Hearing - Reasonable and Customary Charges incurred for necessary care and treatment of loss or impairment of speech or hearing while Hospital Confined. Coverage does not include hearing instruments or devices.

Colorectal Screening - Reasonable and Customary Charges for colorectal cancer examinations and laboratory tests, while Hospital Confined or in an Ambulatory Surgical Center, for: (1) Covered Persons who are 50 years of age or older; (2) Covered Persons who are less than 50 years of age and at a high risk for colorectal cancer; (3) Covered Persons experiencing the following symptoms: bleeding from the rectum or blood in the stool; a change in bowel habits, such as diarrhea, constipation, or narrowing of the stool, that lasts more than 5 days.

The colorectal screening will involve an examination of the entire colon, including the following exams or laboratory tests, or both:

1. An annual fecal immunochemical test in conjunction with a flexible sigmoidoscopy every 5 years;
2. A double-contrast barium enema every 5 years; or
3. A colonoscopy every 10 years; and
4. Any additional medically recognized screening tests for colorectal cancer required by the Director of the Department of Health.

Follow-up screenings are covered as follows:

1. If the initial colonoscopy is normal, follow-up is recommended in 10 years;
2. For Covered Persons with 1 or more neoplastic plyps, adenomatous polyps, assuming that the initial colonoscopy was complete to the cecum and adequate preparation and removal of all visualized polyps follow-up is recommended in 3 years;
3. If single tubular adenoma of less than 1 centimeter (4 for patients with large sessile adenomas greater than 3 centimeters) especially if removed in piecemeal fashion, follow-up is recommended in 6 months or until complete polyp removal is verified by colonoscopy.

Diabetes – Reasonable and Customary Charges for equipment, supplies, medication and a one per lifetime self-management training and patient management, including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin-using diabetes, while Hospital Confined. The self-management diabetes training program must be Medically Necessary as determined by a Doctor. Additional training is covered when a Doctor prescribes the additional training as Medically Necessary because of a significant change in the Covered Person's symptoms or conditions.

EXCEPTIONS

WE DO NOT COVER AN INJURY OR SICKNESS THAT IS EXCLUDED BY NAME OR DESCRIPTION.

THE GROUP POLICY DOES NOT PROVIDE COVERAGE FOR LOSS CAUSED BY, CONTRIBUTED TO, OR RESULTING FROM ANY OF THE FOLLOWING EXCEPTIONS:

1. Injury or Sickness if the loss is covered under these or similar laws:
   worker's compensation ,
   employer's liability, or
   occupational disease laws.

2. Injury or Sickness that results from war or an act of war, whether war is declared or not.

3. Care or supplies that a Covered Person receives in a Hospital or other facility that a government agency runs; however, We will not apply this Exception if:

   (a) The Covered Person receives a charge that he/she has to pay by law, and
   (b) The Hospital or facility would have made the charge even if no insurance existed.

4. The diagnosis and/or treatment of the adenoids, tonsils, gallbladder, reproductive organs, and hernia for the first six months of coverage; however, if We have excluded any one of these conditions by rider, We do not pay any benefit for the condition, regardless of when the treatment takes place; or if such condition is a Preexisting Condition, any benefit consideration will be in accordance with the Preexisting Conditions provision; however, this Exception does not apply to a HIPAA Eligible Individual.

5. Procedures or treatments that are Experimental or Investigational Medicine.

6. Pregnancy and childbirth, except for Complications of Pregnancy.

7. Mental Disorders.

8. Cosmetic surgery however, this Exception does not apply when surgery is required:
   a) To correct damage that results from a covered Injury;
   b) To repair a birth defect of a child born to the Certificateholder and continuously covered under this Policy from its birth; or
   c) For breast reconstruction following a covered mastectomy.

9. Breast reduction and surgery to repair, replace, or remove breast implants;

10. Dental Treatment, unless due to Injury to a Covered Person's natural teeth.

11. A Pre-Existing Condition as defined in the Group Policy, except as stated under DEFINITIONS and TIME LIMIT ON CERTAIN DEFENSES, PRE-EXISTING CONDITIONS.

12. Any attempt at suicide, while sane.

13. An intentionally self-inflicted Injury, while sane.

14. A Covered Person's commission of or attempt to commit a felony, an illegal act, or being engaged in an illegal occupation.

15. A Covered Person being intoxicated, unless such intoxication is the result of a prescription drug taken as prescribed by a Doctor.

16. A Covered Person with a blood alcohol concentration equal to or in excess of .08 gms/dl operating any motor vehicle, including any off-road vehicle, or watercraft.

17. Any procedure for refractive correction, eye refraction or the purchase or fitting of vision or hearing aids, Cochlear Implants and related devices.

18. Weight reduction or treatment of obesity, including exogenous, endogenous, or morbid obesity.

19. Mandibular or maxillofacial surgery to correct growth defects and jaw disproportions or malocclusions; increase vertical dimension; or reconstruct occlusion after one year from a child's date of birth or a child's date of adoption, except where such surgery is for the repair of a congenital anomaly or birth defect of a child born to You or a child that he/she adopts if the child is continuously covered from birth, adoption, or placement for adoption.

20. Treatment provided outside the United States of America, its possessions and territories, except as otherwise provided under Foreign Emergency Treatment.

21. Diagnosis or treatment (including surgery) of sexual dysfunction disorder or inadequacy; or transsexual surgery.

22. Sclerotherapy for veins of the extremities or laser surgery to minimize veins.

23. Routine newborn care.

24. Care in a nursing home or custodial institution; domiciliary care or rest cures.

25. Charges for Medical Services that You or a Covered Person is not legally obligated to pay.

26. Any charges for or relating to: artificial insemination; in-vitro fertilization or any other diagnosis or treatment for the control, promotion, or enhancement of fertility; treatment for impotency; sterilization or reversal of prior sterilization; abortion, unless the life of the mother would be endangered if the fetus were carried to term; or therapeutic abortion.

27. Drugs and supplies provided for home use.

28. Treatment of alcoholism or drug use.

29. False labor; pre-term or premature labor; occasional spotting; prescribed rest while pregnant; morning sickness; hyperemesis gravidarum; or pre-eclampsia. There may be other conditions that relate to a difficult pregnancy that a Doctor can manage.

AUTOMATIC COVERAGE OF NEWBORN AND ADOPTED CHILDREN

Newborns: If the Group Policy provides coverage for Covered Persons other than You, the Policy will also provide coverage for newborn children when they live with You from the moment of birth. This coverage is free for the first 90 days.

Adopted Children: If the Group Policy provides coverage for Covered Persons other than You, the Policy will also provide coverage for adopted children and children who are placed for adoption from the date of the filing of a petition for adoption. This coverage for adopted children is free for the first 60 days of the filing of a petition for adoption if You apply for coverage within 60 days after the filing of the petition for adoption. However, the coverage will be free for the first 60 days from the moment of birth if the petition for adoption and application for coverage is filed within 60 days after the birth of the minor.

In order to continue coverage for a newborn or adopted child, You must do the following:

1. Send Us notice of the child within the 90 days after the date of the child's birth or before the premium due date, whichever is later (or, in the case of an adopted child, within the 60 days after the filing of the petition for adoption or birth of child); and
2. Send Us the additional premium for the child within 90 days of the child's date of birth or within 60 days of the date of petition for adoption or birth of the child.

As long as You pay the extra premium, the child will remain a Covered Person, subject to the Termination of Coverage and Loss of Coverage Eligibility provisions of the Group Policy. Coverage for a child that is placed with You for adoption will continue in accordance with the Termination of Coverage and Loss of Coverage Eligibility provisions, unless the placement is disrupted prior to legal adoption and the child is removed from placement.

We do not require an application for the child unless You have notified Us of the child later than the timeframe as required above.

TERMINATION OF COVERAGE

We can terminate coverage under the Group Policy as of any premium due date under any of the following conditions:

1. You have failed to pay premiums or contributions in accordance with the terms of the Group Policy, or We have not received timely premium payments;
2. You or a Covered Person has performed an act or practice that constitutes fraud with respect to activities under the Group Policy;
3. You no longer reside, live, or work in the PPO service area or in an area where We have authority to do business. We will only apply this provisions if We end coverage uniformly and without regard to any health status related factor of a Covered Person; or
4. We are ceasing to offer coverage in the medical expense market in accordance with applicable state law.

Notice of termination will be provided in accordance with state law.

If coverage under the Group Policy ends and is replaced by a group health insurance plan issued by another insurer or self-funded health care plan, coverage under the Group Policy will continue for any Covered Person who is Hospital Confined on the date coverage under the Group Policy ends. Continuation of such benefits are subject to all terms and conditions the Group Policy, except those relating to termination of benefits. Such benefits will continue until the Hospital Confinement ends or until the maximum benefits available under the Group Policy are paid, whichever occurs first.

Subject to the conditions listed above, We cannot refuse to renew coverage:

1. Just because of a change in a Covered Person's health or the type of work the Covered Person performs; or
2. Just because of the claims filed by or on behalf of a Covered Person, unless the claims are fraudulent.

LOSS OF ELIGIBILITY

Eligibility for continuation of coverage under the Group Policy by a Covered Person ends on the date of the month that coincides with the date of the month shown on the Certificate Schedule and occurs on such date next following the date of the event that causes such termination. If a Covered Person's coverage ends under the Group Policy, in accordance with the paragraphs above, such Person may be eligible for Continuation or Conversion. Please see the Conversion and Continuation Privilege.

RULES FOR ALL COVERED PERSONS - Coverage will end:

1. If the Group Policy is terminated in accordance with the section titled TERMINATION OF COVERAGE; or
2. If You fail to pay the required premium within the time the Grace Period.

RULES FOR ADULT COVERED PERSONS - Coverage will end:

1. For Your spouse if there is a divorce; or
2. If a mentally or physically disabled Covered Person marries or becomes capable of self-support. (See the section titled EXTENSION OF COVERAGE FOR SOME CHILDREN).

If a married Certificateholder dies and his/her spouse is a Covered Person, the spouse will become the Certificateholder.

RULES FOR CHILD COVERED PERSONS - Coverage will end for a child when:

1. The child is no longer a dependent of You;
2. The child gets married; or
3. The child attains the Limiting Age, except for the extension allowed by the section titled EXTENSION OF COVERAGE FOR SOME CHILDREN.

PREMIUM – We will adjust premiums if required under Our rules as of the date coverage ends for a Covered Person. This will occur on a date consistent with the date coverage ends, as described above.

SUCCESSION – If the Certificateholder dies and is survived by other Covered Persons, a new Certificateholder will be named in accordance with the following:

1. If the deceased Certificateholder was married at the time of death and his/her spouse is a Covered Person, the spouse will become the new Certificateholder;

2. If the deceased Certificateholder was married at the time of death and his/her spouse is <u>not</u> a Covered Person, while other Covered Persons survive the deceased Certificateholder, the spouse will become the Certificateholder; or

3. If the deceased Certificateholder was unmarried at the time of death while other Covered Persons survive the deceased Certificateholder, the estate of the deceased Certificateholder shall be entitled to name a new Certificateholder in accordance with the Company's rules in effect on the date of the deceased Certificateholder's death.

EXTENSION OF COVERAGE FOR SOME CHILDREN

When an unmarried dependent child who is a Covered Person has reached the Limiting Age, coverage may continue if the child is, and remains, incapable of sustaining employment by reason of mental retardation or physical disability and who is chiefly dependent upon You for support and maintenance.

ANTEX may ask You to furnish proof of the incapacity or dependency. ANTEX will bear the cost of obtaining such proof. You are expected to notify ANTEX if the incapacity or dependency is removed or terminated in the future.

The premium rate for the handicapped dependent will remain at the child rate.

TOTAL DISABILITY

"Total Disability" means a Covered Person's inability, because of Sickness or Injury, to perform the material and substantial duties of his/her occupation.

If a Covered Person suffers from Total Disability at the time of any termination or discontinuance of this Policy by ANTEX, regardless of the reason for the termination or discontinuance, ANTEX will provide an extension of benefits for a period of 12 months immediately following the date of termination or discontinuance. Benefits payable will be subject to this Policy's regular benefit limits.

CONVERSION PRIVILEGE

If coverage under the Group Policy has been terminated, Covered Persons are entitled to have a conversion policy issued by ANTEX, without evidence of insurability, subject to the following terms and conditions:

1. A conversion policy is not available to a Covered Person if termination of his insurance under the Group Policy occurs:
   a) Because he/she failed to make timely payment of any required premium; or
   b) For any other reason, and he/she had not been continuously covered under the Group Policy, and for similar benefits under any group policy which it replaced, during the entire three (3) months period ending with such termination; or
   c) Because the Group Policy terminated and the insurance was replaced by similar coverage under another group policy within thirty-one (31) days of the date of termination; and

2. Written application and the first premium payment for the conversion policy shall be made to ANTEX not later than thirty-one (31) days after such termination.

The premium for the conversion policy shall be determined in accordance with ANTEX's table of premium rates applicable to the age and class of risk of each person to be covered under that policy and to the type and amount of insurance provided.

The conversion policy shall cover the Covered Persons on the date his/her coverage terminates under the Group Policy. At the option of ANTEX, a separate conversion policy may be issued to cover any dependent. ANTEX shall not be required to issue a conversion policy covering any person if such person is or could be covered by Medicare. Furthermore, ANTEX shall not be required to issue a conversion policy covering any person if:

1. Such person is or could be covered for similar benefits under an individual policy; such person is or could be covered for similar benefits under any arrangement of coverage for an individual in a group, whether insured or uninsured; or similar benefits are provided for or available to such person by reason of any state or federal law; and

2. The benefits under sources described in paragraph (1) above for such person, or benefits provided or available under sources described in paragraph (1) above for such person, together with the conversion policy's benefits would result in overinsurance according to ANTEX's standards for overinsurance.

The conversion policy will not exclude, as a Pre-Existing Condition, any condition covered by the Group Policy; provided, however, that the conversion policy may provide for a reduction of its hospital, surgical, or medical benefits by the amount of any such benefits payable under the Group Policy after the individual's insurance terminates.

COORDINATION OF BENEFITS

The Coordination of Benefits (COB) provision applies when a Covered Person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans does not exceed 100% of the total Allowable expense.

DEFINITIONS

A. A **Plan** is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts:

(1) **Plan** includes: group and nongroup insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

(2) **Plan** does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

B. **"This Plan"** means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. The order of benefit determination rules determine whether This plan is a Primary plan or Secondary plan when the Covered Person has health care coverage under more than one Plan.

When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

D. Allowable expense is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the Covered Person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering the Covered Person is not an Allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered Covered Person is not an Allowable expense.

The following are examples of expenses that are not Allowable expenses:

(1) The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.

(2) If a Covered Person is covered by 2 or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.

(3) If a Covered Person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.

(4) If a Covered Person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary plan's payment arrangement shall be the Allowable expense for all Plans. However, if the provider has contracted with the Secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary plan to determine its benefits.

(5) The amount of any benefit reduction by the Primary plan because a Covered Person has failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

E. Closed panel plan is a Plan that provides health care benefits to Covered Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

F. Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When a Covered Person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

A. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.

B. (1) Except as provided in Paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary.

(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide out-of-network benefits.

C. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

D. Each Plan determines its order of benefits using the first of the following rules that apply:

(1) Non-Dependent or Dependent. The Plan that covers the Covered Person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary plan and the Plan that covers the Covered Person as a dependent is the Secondary plan. However, if the Covered Person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the Covered Person as a dependent; and primary to the Plan covering the Covered Person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the Covered Person as an employee, member, policyholder, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.

(2) Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

(i.) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or
(ii.) If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.

(b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(i.) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
(ii.) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;
(iii.) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or
(iv.) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

1. The Plan covering the Custodial parent;
2. The Plan covering the spouse of the Custodial parent;
3. The Plan covering the non-custodial parent; and then
4. The Plan covering the spouse of the non-custodial parent.

(c) For a dependent child covered under more than one Plan of individuals who are the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

(3) Active Employee or Retired or Laid-off Employee. The Plan that covers a Covered Person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same Covered Person as a retired or laid-off employee is the Secondary plan. The same would hold true if a Covered Person is a dependent of an active employee and that same Covered Person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(4) COBRA or State Continuation Coverage. If a Covered Person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the Covered Person as an employee, member, subscriber or retiree or covering the Covered Person as a dependent of an employee, member, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(5) Longer or Shorter Length of Coverage. The Plan that covered the Covered Person as an employee, member, policyholder, subscriber or retiree longer is the Primary plan and the Plan that covered the Covered Person the shorter period of time is the Secondary plan.

(6) If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This plan will not pay more than it would have paid had it been the Primary plan.

EFFECT ON THE BENEFITS OF THIS PLAN

A. When This plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary plan. The Secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim. In addition, the Secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If a Covered Person is enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed panel plan, COB shall not apply between that Plan and other Closed panel plans.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This plan and other Plans. ANTEX may get the facts it needs from or give them to other organizations or Covered Persons for the purpose of applying these rules and determining benefits payable under This plan and other Plans covering the Covered Person claiming benefits. ANTEX need not tell, or get the consent of, any person to do this. Each Covered Person claiming benefits under This plan must give ANTEX any facts it needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another Plan may include an amount that should have been paid under This plan. If it does, ANTEX may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This plan. ANTEX will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by ANTEX is more than it should have paid under this COB provision, it may recover the excess from one or more of the Covered Persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the Covered Person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

GENERAL PROVISIONS

ENTIRE CONTRACT -- The Entire Contract will consist of:

1. The Group Policy;
2. The Application of the Group Policyholder, which will be attached to the Group Policy;
3. Any Enrollment Applications and attached papers for the proposed Covered Persons; and
4. Any riders, endorsements or amendments issued with or added to the Group Policy or any Certificate which is a part of the Group Policy.

We will deem all the statements provided in the Enrollment Application and attached supplements, except fraudulent statements, as representations and not warranties.

TIME LIMIT ON CERTAIN DEFENSES --

1. MISSTATEMENTS IN THE ENROLLMENT APPLICATION --
We may only use fraudulent misstatements in the Enrollment Application to void coverage under the Group Policy or to deny any claim for loss incurred more than 24 months after the Covered Person's Certificate Date.

2. PRE-EXISTING CONDITIONS --
No claim for loss incurred after the earlier of: (a) the end of a continuous period of 12 months commencing on or after the Covered Person's effective date of coverage under the Group Policy, during which the Covered Person has received no medical advice or treatment in connection with such disease or physical condition or (b) the end of the 2-year period commencing on the effective date of the Covered Person's coverage under the Group Policy will be reduced or denied unless:

(a) The disease or physical condition has been excluded from coverage by name or specific description, and;
(b) Such exclusion is in effect on the date the loss is incurred.

REINSTATEMENT -- Coverage terminates if You do not pay a periodic premium payment before the end of the Grace Period. Our later acceptance of premium, (or one of our authorized agent's acceptance of premium) without requiring an application for reinstatement, reinstates coverage under the Group Policy.

We will require an application for reinstatement. We will subject all representations made in this application to all of the provisions of the Group Policy, including TIME LIMIT ON CERTAIN DEFENSES. If We approve the application for reinstatement, We will reinstate coverage as of the approval date of the reinstatement Enrollment Application. If We do not approve the reinstatement and do not notify You in writing of the disapproval, We must reinstate coverage. The reinstatement will take place on the 45th day following the date of Our receipt of the application for reinstatement.

The reinstated plan only covers loss resulting from:

1. Injury that occurs after reinstatement; and
2. Sickness that begins ten days or more after the Covered Person's date of reinstatement.

In all other respects, the Covered Person's rights and Our rights will remain the same, except as stated in any application attached to the reinstated coverage.

We will apply any premiums that We accept for reinstatement to a period for which You have not paid premiums. We will not apply any premium to any period more than 60 days before the reinstatement date.

WE WILL NOT CONSIDER A REQUEST FOR REINSTATEMENT THAT YOU MAKE MORE THAN 180 DAYS AFTER COVERAGE UNDER THE GROUP POLICY HAS TERMINATED.

GRACE PERIOD -- There is a 31 day grace period for the payment of any premium. If a renewal premium is not paid on or before its due date, it may be paid during the following 31 days. If We do not receive the payment during this Grace Period, We will terminate coverage. Termination will be effective as of the end of the period for which

premium was paid. The Grace Period does not apply if the Company has provided a notice of intent to terminate the Group Policy.

NOTICE OF CLAIMS -- A claimant must give notice of claim within 30 days after a covered loss starts or as soon as reasonably possible. The claimant must give the notice to Us at Our Home Office in Galveston, Texas. The notice must include the claimant's name and his/her Certificate Number.

CLAIM FORMS -- When We receive notice of claim, We will send the claimant forms for filing Proof of Loss. If We do not mail the claimant these forms within 15 days of Our receipt of his/her request, the claimant will have met the Proof of Loss requirement. However, the claimant must still give Us a written statement of the nature and extent of the loss within the time limit stated in the Proof of Loss section.

PROOFS OF LOSS -- The claimant must give written Proof of Loss to the Home Office in Galveston, Texas within 90 days after such loss. If it was not reasonably possible for the claimant to give the Proof of Loss in the time required, We will not reduce or deny the claim as long as the claimant gives proof as soon as reasonably possible. In any event, the claimant must give proof no later than 1 year from the time specified, unless the claimant was legally incapacitated.

TIME FOR PAYMENT OF CLAIMS -- All benefits payable under the Group Policy will be paid immediately upon receipt of Proof of Loss.

We will pay or deny each Clean Claim as follows: (1) if the claim is filed electronically, within 30 days after the date We receive the claim; or (2) if the claim is filed on paper, within 45 days after the date we receive the claim. We will notify the claimant of any deficiencies in the claim not less than 30 days after the date We receive the claim. The notice will give an explanation of any additional information required. We will suspend the claim until We receive the requested information. We will reopen and pay or deny the suspended claim within 30 days after We receive the information requested..

If We fail to pay or deny a Clean Claim or to give notice that We need more information to pay a claim, We will pay the claimant for the period beginning on the 61st day after receipt of the Clean Claim and ending on the Clean Claim payment date (this is called the delinquent payment period), calculated as follows: the amount of the Clean Claim payment times 12% per annum times the number of days in the delinquent payment period, divided by 365. We will pay this penalty without any action by the claimant.

A "Clean Claim" means a claim for payment of health care expenses that is submitted on a HCFA 1500 on a UB92 in a format required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), or on Our standard claim form with all required fields completed in accordance with Our published claim filing requirements. A Clean Claim does not include a claim (1) for payment of expenses incurred during a period of time for which premiums are delinquent; or (2) for which We need additional information in order to resolve the claim.

PAYMENT OF CLAIMS -- We will pay Group Policy benefits to You. If You have assigned benefits, We will pay the benefits to the respective assignee. If You have died, We will pay any unpaid benefits to Your estate. We may pay benefits up to [$1,000] to someone related to You by blood or marriage or to any other person We deem entitled to the benefits if:

1. A court has deemed You incompetent; or
2. You have died and Your estate is not able to execute a valid release.

NO ASSUMPTION OF LIABILITY -- Our payment of any claim does not mean We have assumed liability for future payments for the same condition or any related condition once:

1. We determine that no Medical Service charges exist; or
2. We determine that Our payment was erroneous or inappropriate.

PHYSICAL EXAMINATIONS -- We have the right to have any Covered Person examined as often as reasonably required while a claim is pending for that person. We will pay for the requested physical examination.

LEGAL ACTIONS -- No legal action may be brought to recover on the Group Policy within 60 days after a claimant gives written Proof of Loss. No legal action may be brought after 3 years from the time the Group Policy requires written proof of loss.

LIMITATION OF LIABILITY: You agree that Our liability arising under the Group Policy or in any way related to it is limited to:

(a) Group Policy benefits otherwise payable;
(b) Your reasonable attorneys fees, if any; and
(c) Any statutory penalties that may be imposed.

TERMINATION OF THE GROUP POLICY -- ANTEX or the Group Policyholder may terminate the Group Policy, as described under **TERMINATION OF COVERAGE**, provided written notice is provided 31 days in advance to the other party.

MISSTATEMENTS OF AGE -- If a Covered Person has misstated his/her age, the benefits will be those the premium paid would have purchased if the correct age had been disclosed. However, if on the Certificate Date, We would not have granted coverage because of the Covered Person's correct age, We are only liable for the return of any premiums paid on account of such person.

CONFORMITY WITH STATE STATUTES -- Any provision of the Group Policy which, on the Certificate Date, is in conflict with the laws of the state in which You reside on that date is amended to conform to the minimum requirements of the laws of the state.

ILLEGAL OCCUPATION -- We will not be liable for any loss that results from a Covered Person engaging in an illegal occupation or committing or attempting to commit a felony.

ASSIGNMENT -- No assignment of interest under the Group Policy will be binding upon ANTEX unless and until We receive the original or a duplicate of the assignment at Our Home Office in Galveston, Texas. Any assignment will be subject to any right of offset that We may be entitled to assert. We are not responsible for the validity or sufficiency of any assignment. If We pay the assignor, We are not liable for payment to the assignee.

AUTHORITY, AMENDMENT, AND ALTERATION -- Neither ANTEX nor the Group Policyholder may modify any terms of the Group Policy except by a written agreement signed by one of Our officers. Neither ANTEX nor the Group Policyholder may waive any forfeiture under the Group Policy except by a written agreement signed by one of Our officers. ANTEX may not delegate the authority for the purposes of this provision. ANTEX may amend or change the Group Policy at any time, subject to the laws of the jurisdiction in which We delivered the Group Policy. In this case, We may amend or change the Group Policy by written agreement between the Group Policyholder and Us and without the consent of the Covered Persons or his/her beneficiaries, if any. No agent has the authority to waive an answer to any question in the application, determine insurability, make or alter any contract or waive any of ANTEX's other rights or requirements. No change in the Group Policy will be valid unless evidenced by endorsement on the Group Policy or by a signed amendment to the Group Policy.

ELECTRONIC ACCOUNT DEBIT AUTHORIZATION -- If You have chosen Electronic Account Debit as Your method of payment, You agree that:

1. We are authorized to debit Your named account for required payments;
2. The account debit will be made electronically without the signature of any officer or employee of ANTEX;
3. We will not provide a receipt for any account debit;
4. ANTEX will not incur any liability because of dishonor of the account debit;
5. Upon refusal of the financial institution to honor any attempted debit of the named account, We will cease to debit Your account. We will send You written notice requesting payment in full of the required premium. Upon Your payment of the required premium, We will again begin to debit Your account. However, if You do not pay the required premium, Your coverage will lapse in accordance with the Grace Period provision; and
6. Except as provided in (4) above, the authorization remains effective unless either party ends the authorization. Before ending the authorization, a party must provide the other party at least 30 days advance written notice. We are not liable for amounts debited from Your account prior to Our receipt of written notification to end coverage.

DIRECT PAYMENT TO PUBLIC HOSPITALS AND CLINICS -- Benefits to a Covered Person shall be paid, with or without an assignment from the Covered Person, to public Hospitals or clinics for services and supplies provided to the Covered Person if a proper claim is submitted by the public Hospital or clinic. No benefits shall be paid under this provision to the public Hospital or clinic if such benefits have been paid to the Covered Person prior to receipt of the claim by ANTEX. Payment to the public Hospital or clinic of benefits pursuant to this provision shall discharge ANTEX from all liability to the Covered Person to the extent of the benefits so paid. Nothing in this provision shall be construed to require payment of benefits for the same services or supplies to both the Covered Person and the public Hospital or clinic.

NOTICE TO CERTIFICATEHOLDERS: We are here to serve the Certificateholder. As our Certificateholder, Your satisfaction is very important to Us. If You have a question about Your Certificate, if You need assistance with a problem, or if You have a claim, You should first contact Your insurance agent or Us at 1-800-899-6520. If You do not have Your agent's name, address, or phone number, please contact Us and We will be able to supply the information.

If We at ANTEX fail to provide You with reasonable and adequate service, You should feel free to contact:

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, AR 72201-1904
1-800-852-5494

EXTERNAL REVIEW PROCEDURE – In certain cases, the Certificateholder has the right to request an External Review Procedure, as described in this Section.

The following terms are defined:

Adverse Determination means the Company's determination that an admission, availability of care, continued stay or other Medical Service has been reviewed and, based upon the information provided, the requested payment for the service is denied, reduced or terminated, because:

(a) The requested Health Care service does not meet the Company's requirements for Medical Necessity, or
(b) The requested Health Care service has been found to be "Experimental/Investigational."

In order to qualify as an "Adverse Determination:"

(a) The Adverse Determination must be a Final Adverse Determination, except as may be provided herein.
(b) The Adverse Determination must involve treatment, services, equipment, supplies, or drugs that would require the health benefit plan to expend five hundred dollars ($500) or more of expenditures.

Adverse Determination does not include the Company's determination to deny a Health Care service based upon:

(a) An express exclusion in the health benefit plan other than a general exclusion for "Medical Necessity" or "Experimental/Investigational;"
(b) An express limitation in the health benefit plan with respect to the number of visits, treatments, supplies or services for a covered benefit in a given calendar period or over the lifetime of the Covered Person;
(c) An express limitation in the health benefit plan with respect to a maximum dollar limitation with respect to a covered benefit in a given calendar period or over the lifetime of the Covered Person;
(d) the Company's determination that an individual is not eligible to be a Covered Person;
(e) the Company's determination that treatment, service, or supplies were requested or obtained by a Covered Person through fraud or material misrepresentation.
(f) The health benefit plan's procedure for determining the Covered Person's access to a Health Care Provider, including but not limited to a network access provision;
(g) Illegality of services or the means or methods of administering them;
(h) FDA or other government agency determinations, reports or statements; or
(i) Licensure, permit or accreditation status of a Health Care Provider.

Authorized Representative means:

(a) A person to whom a Covered Person has given express written consent to represent the Covered Person in an External Review;
(b) A person authorized by law to provide substituted consent for a Covered Person; or
(c) When the Covered Person is unable to provide consent, a family member of the Covered Person or the Covered Person's treating Health Care Professional if a family member is unavailable.

Commissioner means the Arkansas Insurance Commissioner.

Covered Benefits or Benefits means those Health Care services to which a Covered Person is entitled under the terms of a health benefit plan.

Covered Person means You. Covered Person shall also mean the Covered Person's Authorized Representative, as defined in this regulation.

Disclose means to release, transfer or otherwise divulge protected Health Information to any person other than the individual who is the subject of the protected Health Information.

Emergency Medical Condition means medical conditions of a recent onset and severity, including, but not limited to, severe pain that would lead a prudent lay person, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

Emergency Services means Health Care items and services furnished or required to evaluate and treat an Emergency Medical Condition.

External Review means a process, independent of all affected parties, to determine if a Health Care service is medically necessary or experimental/ investigational.

Facility means an institution providing Health Care services or a Health Care setting, including but not limited to, hospitals and other licensed inpatient centers, outpatient surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

Final Adverse Determination means an Adverse Determination involving a covered benefit that has been upheld by a health carrier at the completion of the health carrier's internal grievance procedure or Utilization Review procedure. If the health carrier does not have, nor is required by law to have, an internal grievance procedure or Utilization Review procedure, an Adverse Determination shall be considered a Final Adverse Determination.

Health care professional means a physician or other Health Care practitioner licensed, accredited or certified to perform specified health services consistent with state law.

Health Care Provider or Provider means a Health Care Professional or a Facility.

Health Care Services means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.

Health Information means information or data, whether oral or recorded in any form or medium, and personal facts or information about events or relationships that relates to:

(a) The past, present or future physical, mental, or behavioral health or condition of an individual or a member of the individual's family;

(b) The provision of Health Care services to an individual; or

(c) Payment for the provision of Health Care services to an individual.

Independent Review Organization means an entity that conducts independent External Reviews of Adverse Determinations and Final Adverse Determinations.

Medical or Scientific Evidence means the following sources:

(a) Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;
(b) Peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the National Institutes of Health's Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline and MEDLARS database Health Services Technology Assessment Research (HSTAR);
(c) Medical journals recognized by the Secretary of Health and Human Services under Section 1861(t)(2) of the federal Social Security Regulation;

(d) The following standard reference compendia: The American Hospital Formulary Service-Drug; The American Dental Association Accepted Dental Therapeutics; and The United States Pharmacopoeia-Drug Information;

(e) Findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including: The federal Agency for Healthcare Research

and Quality; The National Institutes of Health; The National Cancer Institute; The National Academy of Sciences; The Centers for Medicare and Medicaid Services; Any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of Health Care services; and Any other Medical or Scientific Evidence that is comparable to the sources listed in Subparagraphs (a) through (e).

Medical or Scientific Evidence shall not include published peer-reviewed literature sponsored to a significant extent by a pharmaceutical manufacturing company or medical device manufacturer.

Medically Necessary or Medical Necessity has the same definition as found under the section of the Certificate titled **DEFINITIONS.**

Person means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, a limited liability company, any similar entity or any combination of the foregoing.

Protected Health Information means Health Information that is not subject to disclosure under state and/or federal law.

Retrospective Review means a review of Medical Necessity conducted after services have been provided to a patient, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication for payment.

Utilization Review and Utilization Review Procedure mean the system for reviewing the appropriate and efficient allocation of hospital resources and medical services given or proposed to be given to a patient or group of patients.

Requesting an External Review, General Information - At the time of an Adverse Determination or a Final Adverse Determination, the Company will notify the Covered Person and Health Care Professional in writing of the right to request an External Review.

Before filing a request for an External Review, a Covered Person must exhaust the Company's internal grievance procedures (unless the Company waives this requirement). A Covered Person has exhausted the internal grievance procedure when:

(a) The Covered Person has filed an appeal regarding an Adverse Determination with the Company; and
(b) The Covered Person has not received a written decision on the appeal from the Company within 30 days following the date the Covered Person filed the appeal. (This 30 day requirement does not apply if the Covered Person requested or agreed to a delay of the 30 day requirement); or
(c) The Covered Person has received a written decision regarding the appeal and the Company has made a Final Adverse Determination.

Once the Covered Person has received a Final Adverse Determination, the Covered Person has 60 days to request of External Review. The Covered Person must request an External Review in writing.

When requesting an External Review, the Covered Person will be required to authorize the release of any medical records that may be required for review in making the decision on the External Review. the Company will attach the authorization form to the External Review Notice.

A Covered Person has the right to contact the Commissioner for assistance with the External Review process at any time. The Commissioner's contact information is:

Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201
(501)371-2600 or 1-800-282-9134
insurance.Consumers@Arkansas.gov

Standard External Review – When the Company receives a request for an External Review, it will assign an Independent Review Organization (IRO) to the External Review.

The IRO will conduct a preliminary review to determine if:

(1) The request meets External Review requirements;
(2) The Covered Person has exhausted the Company's internal grievance process (unless the Covered Person is not required to exhaust the grievance process as described in this notice); and
(3) The Covered Person has provided all information and forms required to process an External Review, including the authorization form that the Company provided at the time of the Adverse or Final Adverse determination.

Within 5 business days, the IRO will review the Request and notify the Covered Person whether the request is complete and whether the IRO has accepted the Request. Within 7 business days after the date of receipt of this IRO notice, the Company will provide to the IRO, the Covered Person, and the Covered Person's treating Health Care Professional the documents and any information considered in making the Adverse Determination or Final Adverse Determination, together with any additional information required.

The IRO notice will include a statement that the Company, the Covered Person and the Covered Person's treating Health Care Professional may submit additional information and supporting documentation in writing to the IRO within 7 business days following the date of receipt of the notice. The IRO will consider this information when conducting the External Review. The IRO shall review all of the information and documents received in writing by the Covered Person, the Covered Person's treating Health Care Professional, and the Company.

If the request is not complete, the assigned IRO will, within 5 business days, inform the Company, the Covered Person, and the Covered Person's treating Health Care Professional what information or materials are needed to make the request complete. The IRO will immediately forward copies of any additional information to the Company.

If the request is not accepted for External Review, the assigned IRO will inform the Covered Person, the Covered Person's treating Health Care Professional and the Company in writing within 5 business days of the reasons for its nonacceptance.

In reaching a decision to accept or reject a matter for External Review, the IRO is not bound by any decisions or conclusions reached during the Company's internal grievance procedure or Utilization Review procedure.

Except in the case of the IRO terminating and reversing the Company's Adverse Determination or Final Adverse Determination because the Company failed to provide documents and information to the IRO within an acceptable time frame, failure by the Company or its Utilization Review organization to provide the documents and information within the time frame required will not delay the conduct of the External Review.

If the Company or its Utilization Review Organization fails to provide the documents and information within the time frame required, the IRO may terminate the External Review and make a decision to reverse the Adverse Determination or Final Adverse Determination.

Upon receipt of the information, if any, required to be forwarded to the IRO, the Company may reconsider its Adverse Determination or Final Adverse Determination that is the subject of the External Review.

Reconsideration by the Company of its Adverse Determination or Final Adverse Determination will not delay or terminate the External Review.

The External Review may only be terminated if the Company decides, upon completion of its reconsideration, to reverse its Adverse Determination or Final Adverse Determination and provide coverage or payment for the Health Care service that is the subject of the Adverse Determination or Final Adverse Determination.

Immediately upon making the decision to reverse its Adverse Determination or Final Adverse Determination, the Company shall notify the Covered Person, the Covered Person's treating Health Care Professional, and the IRO in writing of its decision.

The IRO will terminate the External Review upon receipt of the notice from the Company regarding its reversal.

In addition to the documents and information referred to above, the IRO, to the extent the information or documents are available and the IRO considers them appropriate, shall consider the following in reaching a decision:

(1) The Covered Person's medical records;
(2) The treating Health Care Professional's recommendation;
(3) Consulting reports from appropriate Health Care Professionals and other documents submitted by the health carrier, Covered Person, or the Covered Person's treating Health Care Professional;

(4) The most appropriate practice guidelines, which may include generally accepted practice guidelines, evidence-based practice guidelines or any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;
(5) Any applicable written screening procedures, decision abstracts, clinical protocols and practice guidelines used by a health carrier to determine the necessity and appropriateness of Health Care services;
(6) If the Adverse Determination involves a denial of coverage based on a determination that the recommended or requested Health Care services is "experimental" or "investigational," the IRO shall also consider whether:
    (a) The recommended or requested Health Care service or treatment has been approved by the federal Food and Drug Administration for the condition, while realizing that treatments or services are often legitimately used for purposes other than those listed in the FDA approval; or
    (b) Medical or scientific evidence demonstrates that the expected Benefits of the recommended or requested Health Care service or treatment is more likely than not to be more beneficial to the Covered Person than any available standard Health Care service or treatment and the adverse risks of the recommended or requested Health Care service or treatment would not be substantially increased over those of available standard Health Care services or treatments.

Within 45 calendar days after the date of receipt of the request for an External Review, the IRO shall provide written notice of its decision to uphold or reverse the Adverse Determination or the Final Adverse Determination to the Covered Person, the Covered Person's treating Health Care Professional, and the Company.

The IRO notice will include:
(a) A general description of the reason for the request for External Review;
(b) The date the IRO received the assignment from the health carrier to conduct the preliminary review of the External Review request;
(c) The date the External Review was conducted, if appropriate;
(d) The date of its decision;
(e) The principal reason or reasons for its decision;
(f) The rationale for its decision; and
(g) References to the evidence or documentation, including the practice guidelines, considered in reaching its decision.

If the Adverse Determination involves a denial of coverage based on a determination that the recommended or requested Health Care services is "experimental" or "investigational," the IRO shall also consider whether:

(i) A description of the indicators relevant to determining whether there is sufficient evidence to demonstrate that the recommended or requested Health Care service or treatment is more likely than not to be more beneficial to the Covered Person than any available standard Health Care services or treatments and the adverse risks of the recommended or requested Health Care service or treatment would not be substantially increased over those of available standard Health Care services or treatments; and

(ii) A description and analysis of any Medical or Scientific Evidence considered in reaching the opinion.

Upon receipt of a notice of a decision reversing the Adverse Determination or Final Adverse Determination, the Company will immediately approve the coverage that was the subject of the Adverse Determination or Final Adverse Determination.

The assignment by the Company of an approved IRO to conduct an External Review in accordance with this section shall be fair and impartial. the Company and the IRO shall comply with standards approved by the Commissioner to ensure fairness and impartiality in the assignment by health carriers of approved IRO to conduct External Reviews.

Expedited External Review – A Covered Person may make a request for an Expedited External Review at the time the Covered Person receives an Adverse Determination or a Final Adverse Determination.

The Covered Person may request an expedited External Review of an Adverse Determination if:

(a) The Covered Person has a medical condition where the timeframe for completion of an expedited review of an appeal set forth in the Company's internal grievance procedure or Utilization Review procedure would seriously jeopardize the life or health of the Covered Person or would jeopardize the Covered Person's ability to regain maximum function; or

(b) The Adverse Determination involves a denial of coverage based on a determination that the recommended or requested Health Care service or treatment is "experimental" or "investigational," and the Covered Person's treating physician certifies in writing that the recommended or requested Health Care service or treatment would be significantly less effective if not promptly initiated.

Note: A Covered Person may file a request for an expedited External Review at the same time the Covered Person files a request for an expedited review of an appeal under the Company's grievance or utilization review procedure if:

(a) The Covered Person has a medical condition where the timeframe for completion of an expedited review of an appeal set forth in the Company's internal grievance procedure or utilization review procedure would seriously jeopardize the life or health of the Covered Person or would jeopardize the Covered Person's ability to regain maximum function; or

(b) The Adverse Determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is "experimental" or "investigational," and the Covered Person's treating physician certifies in writing that the recommended or requested health care service or treatment would be significantly less effective if not promptly initiated.

The IRO will determine whether the Covered Person shall be required to complete the Company's expedited internal grievance procedure or Utilization Review procedure before it conducts the expedited External Review. Upon a determination that the Covered Person must first complete the expedited internal grievance review procedure or Utilization Review procedure, the IRO immediately shall notify the Covered Person and the Covered Person's treating Health Care Professional of this determination and that it will not proceed with the expedited External Review until the expedited internal grievance procedure or Utilization Review procedure is completed and the Adverse Determination or Final Adverse Determination is upheld.

The Covered Person may request an expedited External Review of a Final Adverse Determination if:

(a) The Covered Person has a medical condition where the timeframe for completion of a standard External Review would seriously jeopardize the life or health of the Covered Person, or would jeopardize the Covered Person's ability to regain maximum function; or

(b) The Final Adverse Determination concerns:

(i) An admission, availability of care, continued stay or Health Care service for which the Covered Person received Emergency Services, but has not been discharged from a Facility; or

(ii) A denial of coverage based on a determination that the recommended or requested Health Care service or treatment is experimental or investigational, and the Covered Person's treating physician certifies in writing that the recommended or requested Health Care service or treatment that is the subject of the request would be significantly less effective if not promptly initiated.

At the time the Covered Person makes a request for an expedited External Review, the Covered Person or the Covered Person's treating Health Care Professional shall submit additional information and supporting documentation that the IRO will consider when conducting the expedited External Review.

At the time the Company receives a request for an expedited External Review, the Company will immediately assign an IRO to the case.

At the time the Company assigns an IRO to conduct the expedited External Review, the Company shall immediately provide or transmit all documents and information considered in making the Adverse Determination or Final Adverse Determination, as well as any additional information and supporting documentation, to the IRO, the Covered Person, and the Covered Person's treating Health Care Professional via electronically, facsimile or any other available expeditious method.

The IRO will, as expeditiously as the Covered Person's medical condition or circumstances require, but in no event more than 72 hours after the date of receipt of the request for an acceptable expedited External Review:

(a) Make a decision to uphold or reverse the Adverse Determination or Final Adverse Determination; and
(b) Notify the Covered Person, the Covered Person's treating Health Care Professional, and the Company of the decision.

If the notice from the IRO was not in writing, within 2 days after the date of providing that notice, the IRO shall:

(a) Provide a written or electronic media confirmation of the decision to the Covered Person and the Company; and
(b) Include the information required for a Standard External Review Notice.

In reaching a decision, the IRO is not bound by any decisions or conclusions reached during the health carrier's Utilization Review process or the Company's internal grievance process.

Upon receipt of notice of a decision reversing the Adverse Determination or Final Adverse Determination, the Company will immediately approve the coverage that was the subject of the Adverse Determination or Final Adverse Determination.

An expedited External Review may not be provided for adverse or Final Adverse Determinations involving a Retrospective Review.

Binding Nature of External Review Decision -

(a) An External Review decision is binding on the Company except to the extent the Company has other remedies available under applicable federal or state law.

(b) An External Review decision is binding on the Covered Person except to the extent the Covered Person has other remedies available under applicable federal or state law.

(c) A Covered Person may not file a subsequent request for External Review involving the same Adverse Determination or Final Adverse Determination for which the Covered Person has already received an External Review decision pursuant to this regulation.

Filing Fees –

(a) Except in the case of a request for an expedited External Review, at the time of filing a request for External Review, the Covered Person shall submit to the IRO a filing fee of $25 along with the information and documentation to be used by the IRO in conducting the External Review.

(b) Upon application by the Covered Person, the Commissioner may waive the filing fee upon a showing of undue financial hardship.

(c) The filing fee shall be refunded to the person who paid the fee if the External Review results in the reversal, in whole or in part, of the Company's Adverse Determination or Final Adverse Determination that was the subject of the External Review.

(d) the Company against which a request for a standard External Review or an expedited External Review is filed shall pay the cost of the IRO for conducting the External Review.

AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS
HOME OFFICE: ONE MOODY PLAZA
GALVESTON, TEXAS

GROUP HOSPITAL INSURANCE CERTIFICATE

THE GROUP POLICY PROVIDES COVERAGE FOR HOSPITAL EXPENSES DESCRIBED IN THE GROUP POLICY AND THIS CERTIFICATE. WHEN SELECTED, A PREFERRED PROVIDER COMPONENT IS INCLUDED WITH THIS COVERAGE.